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A COMMUNITY REINFORCEMENT PLUS VOUCHERS APPROACH: TREATING COCAINE ADDICTION (CRA+V-2) MODULE 2

3 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Intermediate

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Last Updated: 2026

Approved by such credentialing bodies as:

• National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564

• National Board of Certified Counselors (NBCC) #6310

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— Maya Angelou

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ABOUT THE INSTRUCTOR

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He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of Interviewing: Theories, Techniques, and Practices, 5th edition published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the Journal of Addictions and Offender Counseling as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

Skills-Based Interventions in Substance Use Treatment: Current Evidence

Module 2 of the CRA+Vouchers series focuses on the practical clinical skills that make the approach work: functional analysis, drug refusal training, self-management planning, problem solving, and vocational counseling. These are the session-by-session tools that translate the CRA framework into behavioral change. Recent research has examined how these skill-building components perform both within the CRA model and as elements of broader psychosocial treatment for stimulant use disorders.

A 2024 Cochrane systematic review of psychosocial interventions for stimulant use disorder — encompassing 64 randomized controlled trials with 8,241 participants — found that skills-based treatments reduced drug use frequency with high-certainty evidence and "probably increase continuous abstinence at the end of treatment." The review identified that the most critical contribution of psychosocial interventions may be retention: "many people with stimulant use disorders leave treatment prematurely," and treatments that build concrete, transferable skills give clients reasons to stay engaged beyond the initial phase of treatment (Minozzi et al., 2024). The functional analysis, refusal training, and self-management planning covered in this module directly address this retention challenge by equipping clients with tools they can use immediately and independently.

The vocational counseling component of this module reflects a dimension of recovery that has received increasing research attention. A 2024 study examining recovery capital — the resources that support sustained recovery — found that, specifically among opioid intervention court (OIC) participants, holding a high-school diploma or GED at baseline predicted significantly faster gains in recovery capital over time. The same effect was not statistically significant for clients in traditional drug treatment court, suggesting that educational attainment matters most for the OIC subgroup with the lowest baseline recovery capital (Knapp et al., 2024). For CRA practitioners, this reinforces the importance of the vocational counseling sessions described in this module — particularly with opioid-court clients whose initial recovery resources are thinnest: employment and education are not peripheral to recovery but core components of the reinforcement environment CRA seeks to build.

The implementation challenge for skills-based interventions like those in this module remains significant. A 2023 review noted that despite strong evidence, contingency management and skills-based CRA components are underutilized outside the VA system, with barriers including regulatory concerns, funding limitations, and practitioner misconceptions about reinforcement-based treatment (Rawson et al., 2023). The 2024 ASAM/AAAP clinical practice guideline addressed this gap by formally establishing contingency management as "the current standard of care for treatment of" stimulant use disorders (ASAM/AAAP Clinical Guideline, 2024) — a designation that should accelerate adoption of the skills-based interventions this module teaches.

A 2024 randomized controlled trial testing the Community Reinforcement Approach with 60 patients found that CRA combined with standard care produced "significant increase in the quality of life of participants" compared to standard treatment alone. The researchers noted that CRA functions as "an effective and adaptable treatment approach" — adaptable being a key word, since the skills covered in this module (functional analysis, refusal training, problem solving) can be tailored to each client's specific reinforcement patterns and risk situations (Khalid et al., 2024).

Acknowledgments

The development of this manual was supported, in part, by several research grants from the National Institute on Drug Abuse. This manual was written by Drs. Alan J. Budney and Stephen T. Higgins under Contract Number N-01DA4-2205 with the National Institute on Drug Abuse. Dr. Lisa Onken, the NIDA Project officer, offered valuable guidance and comments throughout the preparation of this manual.

The material presented in this manual is the result of extensive research under the direction of Dr. Higgins and colleagues at the University of Vermont. The development of this therapy model for treatment of drug abuse is built on the work of Dr. Nathan Azrin and colleagues who first developed the Community Reinforcement Approach for treatment of alcoholism and Dr. Maxine Stitzer and colleagues who pioneered the use of contingency-management procedures in the treatment of illicit drug abuse. The work of many others was also quite valuable as is acknowledged in the relevant portions of this manual.

The assistance of many dedicated therapists and research assistants who participated in the clinical trials of this therapy protocol is gratefully acknowledged and appreciated.

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National Institute on Drug Abuse
NIH Publication Number 98-4309
Printed April 1998

Foreword

More than 20 years of research has shown that addiction is clearly treatable. Addiction treatment has been effective in reducing drug use and HIV infection, diminishing the health and social costs that result from addiction, and decreasing criminal behavior. The National Institute on Drug Abuse (NIDA), which supports more than 85 percent of the world's research on drug abuse and addiction, has found that the most effective treatment approaches include both biological and behavioral components.

To ensure that treatment providers apply the most current science-based approaches to their patients, NIDA has supported the development of the "Therapy Manuals for Drug Addiction" series. This series reflects NIDA's commitment to rapidly applying basic findings in real-life settings. The manuals are derived from those used efficaciously in NIDA-supported drug abuse treatment studies. They are intended for use by drug abuse treatment practitioners, mental health professionals, and all others concerned with the treatment of drug addiction.

The manuals present clear, helpful information to aid drug treatment practitioners in providing the best possible care that science has to offer. They describe scientifically supported therapies for addiction and give specific guidance on session content and how to implement these techniques. Of course, there is no substitute for training and supervision, and these manuals may not be applicable to all types of patients nor compatible with all clinical programs or treatment approaches. These manuals should be viewed as a supplement to, but not a replacement for, careful assessment of each patient, appropriate case formulation, ongoing monitoring of clinical status, and clinical judgment.

The therapies presented in this series exemplify the best of what we currently know about treating drug addiction. As our knowledge evolves, new and improved therapies are certain to emerge. We look forward to continuously bringing you the latest scientific findings through manuals and other science-based publications. We welcome your feedback about the usefulness of this manual series and any ideas you have on how it might be improved.

Alan I. Leshner
Director
National Institute on Drug Abuse

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Background

Cocaine dependence remains an intractable U.S. public health problem that contributes to many of our most disturbing social problems, including the spread of infectious disease (e.g., HIV, hepatitis, tuberculosis), crime, violence, poverty, traumatic injuries, and neonatal drug exposure. Although the overall number of cocaine users has decreased during the past decade, the number of heavy users (once a week or more) has increased, along with other disturbing trends such as increases in the number of cocaine-related emergency-room admissions, deaths, and admissions to State-supported treatment facilities.

Psychosocial Interventions

There is no consensus on how to treat cocaine dependence. No pharmacotherapy is available, but even if one should be developed, effective psychosocial treatments would still be necessary to address the multiple problems common in this population. Research on psychosocial treatments for cocaine dependence has been relatively fruitful, and several effective treatments have been reported (Carroll et al. 1991, 1994a,b; Higgins et al. 1991, 1993a, 1994a, 1995.)

One such intervention, CRA + Vouchers, is the focus of this manual. This treatment integrates a community reinforcement approach (CRA), originally developed as an effective treatment for alcohol dependence (Myers and Smith 1995), with an incentive program (Vouchers) wherein patients can earn points exchangeable for retail items by remaining in treatment and cocaine abstinent. This multicomponent treatment as a whole and several of its components have been demonstrated to be efficacious in controlled clinical trials conducted with cocaine-dependent adults in outpatient clinics. Its applicability to younger individuals and in other settings has not been tested.

This manual provides the necessary guidance for therapists to implement CRA + Vouchers as a whole as well as the individual components that are effective as adjuncts to other treatments.

Supporting Research

Our group has conducted five controlled clinical trials examining the efficacy of CRA + Vouchers. In two trials, CRA + Vouchers was superior to standard drug abuse counseling in retaining patients in treatment and documenting clinically significant periods of continuous cocaine abstinence (Higgins et al. 1991, 1993a). For example, in a 24-week study, more than 75 percent of those who received CRA + Vouchers completed 24 weeks of outpatient treatment compared to only 11 percent of patients who received drug abuse counseling. Several months of continuous cocaine abstinence were documented in the majority of patients treated with CRA + Vouchers versus only 10 percent among those treated in a standard counseling group.

A third trial further assessed the reliability of the positive outcomes observed with CRA + Vouchers and began to identify which of its several components were clinically active (Higgins et al. 1994a). A 24-week, randomized trial was conducted to assess the efficacy of the vouchers component. Cocaine-dependent outpatients were randomly assigned to receive CRA + Vouchers or CRA alone. Patients who received CRA + Vouchers stayed in treatment significantly longer and achieved greater durations of continuous cocaine abstinence than patients assigned to CRA alone. A fourth clinical trial was recently completed in our clinic, further supporting the efficacy of the voucher program in promoting sustained periods of cocaine abstinence among patients enrolled in outpatient care.

Another component, wherein patients' significant others were used to provide social reinforcement when the patient successfully abstained from cocaine abuse, was recently tested. Preliminary research suggested that this was an effective intervention (Higgins et al. 1994b). However, a randomized clinical study yielded no evidence to support the efficacy of this approach, and it was discontinued.

In two of the trials with positive outcomes, followup assessments were conducted 12 months after treatment entry. In each trial, evidence supported the greater efficacy of the complete treatment package (CRA + Vouchers) compared to drug abuse counseling or CRA alone (Higgins et al. 1995). For cocaine-dependent adults, the efficacy of incentives for remaining in treatment and for providing objective evidence of recent cocaine abstinence has received further scientific support. In a recent review of the scientific literature, 11 of the 13 studies (85 percent) on the use of incentives in the treatment of cocaine dependence showed positive treatment effects (Higgins 1996).

Use With Other Populations

CRA + Vouchers was developed and tested in Burlington, Vermont, a small metropolitan area. To assess the generality of this treatment approach to large metropolitan areas, additional trials were conducted in methadone-maintenance clinics located in Baltimore and San Francisco with patients who abused cocaine while in treatment for opioid dependence (Silverman et al. 1996a; Tusel et al. 1995).

Only the voucher program was examined in these 3-month randomized trials. Vouchers significantly increased cocaine and other drug abstinence, thereby demonstrating the applicability of incentives for reducing cocaine abuse to abusers residing in large metropolitan areas.

Several recent adaptations of the voucher program for use with special populations also appear promising. One application was with schizophrenic cocaine abusers (Shaner et al. 1997). Another involves the use of the voucher program to increase treatment retention, abstinence, and participation in prenatal and postnatal care among pregnant and postpartum cocaine-abusing women (Kirby et al. in press).

Concurrent Alcohol Dependence

We were surprised to learn that approximately 60 percent of our patients were also alcohol dependent. Disulfiram (Antabuse) therapy, with clinic or family supervision to assure medication compliance, is a standard component of CRA with alcoholics. Thus, we quickly adopted the practice for simultaneously treating alcohol and cocaine dependence in these dually dependent patients. In a chart review of these patients, disulfiram therapy was associated with significant decreases in drinking and, unexpectedly, cocaine use as well (Higgins et al. 1993b).

Carroll and colleagues subsequently reported results consistent with these findings in a pilot clinical trial (Carroll et al. 1993). In that study, disulfiram therapy was compared to naltrexone therapy in a population of outpatients who abused cocaine and alcohol. Patients were randomized to receive one of the two medications as an adjunct to once-weekly psychotherapy. Disulfiram therapy resulted in reductions in drinking and cocaine use that were three or more times greater than those with naltrexone therapy. A larger, randomized trial on the efficacy of disulfiram therapy in patients who abuse cocaine and alcohol was completed recently by this same group and again, cocaine use was significantly reduced via disulfiram therapy (Carroll, personal communication).

Program Overview

Cocaine dependence is a life-threatening problem characterized by behavior patterns that make treatment entry, compliance, and lifestyle change very difficult. Therefore, CRA + Vouchers providers are expected to make every effort to facilitate treatment initiation, ongoing attendance, and behavior change that will support a drug-free lifestyle. The general approach taken to achieving this goal is perhaps best described as individualized, empirically based, and behavioral.

Although patients are expected to be extremely active participants in the treatment process, therapists should expect difficulties and noncompliance with therapeutic activities. These problems should be defined for what they are, problem behaviors in need of therapy, *not* as a reason to discharge patients from treatment.

Lifestyle Changes

Increasing cocaine abstinence is the primary goal of CRA + Vouchers. To achieve and maintain abstinence, patients need to make major lifestyle changes, particularly in four areas:

- Family relationships
- Recreational activities
- Social networks
- Vocation

High levels of satisfaction in a cocaine-free lifestyle are needed to compete with the reinforcement derived from drug use and the drug-using lifestyle. Therefore, increasing satisfaction in these areas is a major goal for reducing the probability of continuing or resuming cocaine use.

Patients are assessed at intake in each of these areas, and individual treatment goals are developed by the therapist and patient together. Specific types of counseling and skills training are provided on an as-needed basis, depending on each patient's lifestyle change goals and the skills needed to achieve those goals. Therapists are expected to

facilitate achievement of targeted goals through extensive outreach whenever necessary.

Vouchers

Urinalysis testing is used to measure the patient's progress in achieving cocaine abstinence, which is the basis for receiving positive reinforcement (social and material) to further increase abstinence. Cocaine abstinence is difficult to achieve and may not result in sufficient, immediate natural rewards, particularly in its early stages. The treatment program provides prompt reinforcement to keep the abstinence going as well as additional motivation to abstain by using vouchers. The points accumulated under this system can be spent for anything that contributes to the patient's treatment goals. Purchases are made by staff with the approval of the therapist.

Other Drug Abuse

Cocaine abusers frequently abuse multiple substances, and more than half use alcohol and marijuana excessively or in conjunction with cocaine. CRA + Vouchers routinely initiates interventions to decrease other drug use, including disulfiram therapy when appropriate to help patients increase alcohol abstinence. The subject of other drug abuse is introduced at intake, and therapy is started immediately, if appropriate.

Patients are always counseled that abstinence from all other drugs of abuse, including alcohol, is the most direct and surest way to increase their chance of success in dealing with their cocaine dependence. However, it is quite common for cocaine abusers to *not* consider their alcohol or other drug use a problem. The treatment philosophy of CRA + Vouchers in this regard is to first and foremost provide patients with treatment for the problem for which they sought help - cocaine dependence.

Treatment Parameters

Schedule

CRA + Vouchers is designed as a 24-week treatment program. During weeks 1 - 12, the therapist schedules two 60-minute individual counseling sessions each week. Additional patient contacts in the form of brief phone calls or in-person sessions are employed as needed. During weeks 13 - 24, the therapist schedules one 60-minute counseling session each week, depending on the patient's needs. Urinalysis monitoring is scheduled for three times a week (e.g., Monday, Wednesday, Friday)

during weeks 1 - 12 and twice a week (Monday, Thursday) during weeks 13 - 24.

Components

CRA + Vouchers includes a variety of skills-training components **(**exhibit 1**)**, but not all patients need or receive all components. Training is tailored to the needs of the individual and is focused on achieving and maintaining cocaine abstinence. Patients are taught to identify their pattern of cocaine use and to develop drug-refusal skills and strategies

Exhibit 1.- Sample Schedule

Week 1:	Treatment Plan Development/Goal Setting
Week 2:	Functional Analysis/Sleep Hygiene (or Relationship Counseling)
Week 3:	Functional Analysis/Employment Counseling
Week 4:	Employment Counseling/Functional Analysis (or Rela tionship Counseling)
Week 5:	Employment Counseling/Drug Refusal Training/HIV/ AIDS Prevention (or Relationship Counseling)
Week 6: (or	Social/Recreational Counseling/Social Skills Training Relationship Counseling)
Week 7: (or	Social/Recreational Counseling/Social Skills Training Relationship Counseling)
Week 8:	Social/Recreational Counseling/Social Skills Training
Week 9:	Sleep Hygiene/Employment Counseling
Week 10:	Sleep Hygiene/Social/Recreational Counseling (or Relationship Counseling)
Week 11:	Relaxation Training (or Relationship Counseling)
Week 12:	Relaxation Training/Review Treatment Progress/Set Goals for weeks 13-24
Weeks 13-24:	New Components are added or counseling continues to focus on changes in the areas addresses during the first 12 weeks.

for avoiding or coping with situations that are high risk for cocaine use (i.e., functional analysis and self-management planning). Skills training in other areas (e.g., assertiveness, communication, relaxation) is also provided as needed to help patients abstain from cocaine and other substance abuse.

The order in which these components are delivered may vary depending on the needs and priorities of the individual patient. For example, functional analysis training is usually scheduled for sessions two through four. However, if a patient has important practical needs (e.g., housing) that must be addressed during these sessions, the therapist may assist in solving those problems first.

The number of sessions used to address each problem is also flexible. For example, one patient may receive four sessions of social skills training, while another may receive only two sessions. Individualized treatment plans are developed for patients based on their particular needs. The therapist and patient come to a collaborative decision concerning which components will be implemented during the program and the order in which they will be delivered.

Structure

Treatment is delivered through individual counseling. Although each patient's treatment sessions will be somewhat different in content and focus of behavior change interventions, all sessions follow the same basic structure.

In general, sessions focus on the areas for change listed in the individual's treatment plan. During each session, the therapist and patient discuss progress and problems in each targeted area. The specific goals are evaluated, and plans of action are initiated. Sessions also focus on the development of behavioral skills important for gaining and maintaining abstinence. Behavioral rehearsal and role-playing are regular in-session activities when skills training is scheduled.

Clinical Approach

While therapists must develop their own style of counseling, CRA + Vouchers therapists must also adopt certain guidelines to assure the integrity of the treatment. The guidelines presented here are designed to facilitate adherence to this treatment protocol. They reflect a treatment philosophy and conceptualization of drug dependence that is consistent with scientific studies on determinants of drug abuse. Since this approach differs at times from other perspectives on drug dependence, such as the disease model and self-medication model, the counseling approach also differs in some respects.

Counseling Style

Flexibility

Flexibility in appointment scheduling and goal setting is important for both treatment retention and facilitating progress toward target goals. Particularly in the initial stages of treatment, therapists must try to work around patients' schedules and make counseling as convenient for them as possible. The therapist's attitude should reflect an effort to meet the individual patient's needs.

Some patients may be oppositional, disorganized, inflexible, or ambivalent about participating in treatment. From a CRA + Vouchers perspective, such characteristics are part of the drug-dependence problem and thus behaviors that need to be changed over time. For example, therapists should -

- Tolerate tardiness to sessions and try to have a full session
- even when patients are late.
- Tolerate patients who must leave early from sessions.
- Be willing to meet patients almost any time of day.
- Set up meetings out of the office if necessary.

With difficult patients, once an effective working relationship is established, the therapist can begin to ask for more reasonable behavior regarding scheduling and regular participation. Improvements in these areas should become an explicit part of the individualized treatment

plan. Usually such a plan involves graded steps toward improvements (i.e., shaping by successive approximation).

Flexibility in goal setting is also very important. For example, if the therapist thinks alcohol abstinence should be a goal but the patient is unwilling to accept that goal, a compromise is reached. Similarly, if the therapist thinks that regular employment should be a goal but the patient voices strong resistance, it is put on hold. In general, therapists should express what they think are optimal goals, but if patients are not ready to make these changes, their positions are respected. The therapist's goal then becomes helping patients progress to the point where they may want to work on these goals. In the meantime, alternative goals are set, and the issues that were met with resistance can continue to be discussed during the course of treatment.

Empathy

Therapists must exhibit empathy and good listening skills. They should convey an understanding of the patient's situation and its inherent difficulties. In the initial stage of treatment, active listening skills can be used to help develop an effective relationship and to facilitate goal-setting. As a general rule, confrontation is strongly discouraged as a means of gaining compliance with therapeutic activities and goals. Rather, therapists should use their professional counseling skills and appropriate behavioral procedures (e.g., prompts, shaping successive approximations, social reinforcement) to gain treatment compliance.

For example, if patients are constantly late for appointments, therapists should not lecture them on promptness or lack of motivation but, instead, facilitate a discussion about the time demands of treatment and how they may conflict with important or desirable activities. Therapists can then engage the patients in problemsolving and ask them whether changing the appointment times or providing assistance with transportation would make it easier for them to attend regularly.

Throughout treatment, empathy should be shown whenever patients are ambivalent about or having difficulty making changes in any problem area. Nonjudgmental feedback is used to help patients make decisions about specific goals or lifestyle changes. Therapists avoid making moral or value judgments and, instead, exhibit genuine empathy and consideration for the difficult decisions and behavior changes patients must contemplate.

Active Involvement

CRA + Vouchers requires both therapists and patients to adopt an active, can-do, make-it-happen attitude throughout treatment. Active problemsolving becomes a routine part of the therapeutic relationship. Therapists do whatever it takes to help patients make lifestyle changes. This includes taking patients to appointments or job interviews, initiating recreational activities with them, scheduling sessions at different

times to accomplish specific goals, having patients make phone calls while in the office, assisting them with appointments, and searching newspapers for job possibilities or recreational events.

The therapist's motto is "we can make it happen." Therapists try to model and in other ways facilitate this same attitude in patients. Patients should be encouraged to be doers rather than talkers, and therapists must model action behavior whenever appropriate.

One caution. Therapists must always use good judgment regarding their own safety when planning outreach interventions. Some patients or their living environments may present some cause for concern. In those instances, other staff members should go with the therapist. If staff are still not comfortable with the safety issues, the intervention should be postponed or canceled.

Directive but Collaborative

CRA + Vouchers treatment encourages patients to set lifestyle change goals. Therapists guide the patients in setting appropriate and effective goals by enlisting information and suggestions from them. Therapists are also expected to have ideas about specific behavior changes necessary for increasing cocaine abstinence and ways to implement such changes. However, therapists must be careful not to present their views in an authoritarian style that makes patients feel that they are being told what to do. The task is to have patients actively participate in the development of their treatment plan so they feel that the plan is theirs.

Therapists should assume the role of both teacher and coach when helping patients develop new skills and behavior patterns. They can provide expert knowledge to help solve the problems for which the patients ask for help and then coach, train, and encourage patients as they try to put these skills into action.

Social Reinforcement

Therapists should provide social reinforcement frequently for all appropriate efforts and changes exhibited by patients. They should take advantage of all opportunities to help patients feel that they are making progress. This is important because, for many patients, change will be slow and difficult. The social reinforcement provided by therapists and clinic staff may be the only source of reward and encouragement available to patients during the early stages of the program.

Counseling Techniques

Therapists using CRA + Vouchers must have a good understanding of behavioral principles as well as sound counseling skills. A good working knowledge of behavioral principles and their application will allow therapists to effectively provide rationales for each treatment component,

model appropriate skills, and serve as credible, competent professionals who can help people with many difficult issues.

Behavioral Techniques

As patients try to take active steps toward specific lifestyle changes, therapists should *not* expect them to readily set appropriate goals, initiate goal-directed behavior, and maintain these new behaviors simply because a well-meaning person encourages them to do so. Significant obstacles will arise that will make the targeted lifestyle changes difficult to achieve.

For example, engaging in a new prosocial recreational activity may involve interaction with nondrug users unfamiliar to the patient. The thought of entering this situation can produce anxiety and avoidance behavior. Similar obstacles may arise when patients try to attend educational classes, go for job interviews, or ask someone for a date. Explanations for noncompliant behavior may include lack of the skills necessary to complete the task, avoidance due to a history of prior failure in similar situations, and loss of something valued by the patient if change is implemented, to name a few possibilities. The therapists' responsibility is to maximize the probability that patients will carry through and achieve the desired behavior change. Behavioral procedures are the therapeutic tools used to increase the probability of compliance with therapeutic activities and success in meeting goals.

Some of the most important and frequently used behavioral principles and procedures that CRA + Vouchers therapists must master are -

- Behavioral contracting.
- Effective goal-setting.
- Modeling/role playing.
- Shaping successive approximations.
- Self-monitoring.
- Therapist prompting/monitoring.
- The Premack principle.
- Skills training (e.g., social skills, problemsolving, task analysis, re laxation, time management).

Additional Resources

It is beyond the scope of this manual to provide training or guidelines for how and when to apply basic behavioral procedures that will help patients meet targeted lifestyle change goals. Detailed protocols are provided for some of the procedures that are primary components of CRA + Vouchers, but in general, therapists must be experienced in applying behavioral procedures or be supervised by someone who has

that experience. The following texts are recommended to help train and guide therapists in basic behavioral principles and procedures.

- Goldfried, M.R., and Davison, G.C. *Clinical Behavior Therapy* . New York: John Wiley and Sons, 1994.
- Meichenbaum, D., and Turk, D. *Facilitating Treatment Adherence: A Practitioner's Guidebook.* New York: Plenum Press, 1987.
- Miller, L.K. *Behavior Analysis for Everyday Life* . Pacific Grove, CA: Brooks/Cole, 1984.
- Sulzer-Azaroff, B., and Meyer, G.R. *Behavior Analysis for Lasting Change.* Fort Worth, TX: Holt Rinehart and Winston, 1991.

Progress Graphs

An effective way to demonstrate progress, or lack of it, to patients is to set measurable goals and record progress on graphs. The most important would be the cocaine urinalysis graph. This shows the cumulative number of cocaine-negative test results plotted as a function of consecutive tests conducted to date in treatment. Clinic attendance can also be presented graphically.

Specific target behaviors can be recorded on graphs so that progress can easily be viewed by both patient and therapist. For example, if the goal is to make four job contacts each day, a bar graph with days of the week on the x axis and number of job contacts on the y axis would be created, and a goal line set at four would be drawn across the graph. If the goal is to spend 10 hours each week in social/recreational activities, a cumulative record, by week, might be used to record progress.

Counseling Structure

The therapist's primary role in each session is to gain active participation from patients and to make sure the session stays focused on a preset plan. The task may be made difficult if the cocaine abuser comes to sessions with clinical issues other than those included in the treatment plan. To effectively deal with such issues, the therapist must skillfully demonstrate appropriate concern but not allow the session to lose focus. The session plan should be followed in every session, except in extreme emergencies. The plan can be structured to accommodate unexpected issues without necessarily altering the preset goals for the session. The therapist's task is to stay in control of the session and ensure that adequate time is available to cover the designated issues.

Preparation

Therapists should prepare for each session by reviewing the rationale for the component to be delivered as well as any didactic material to be presented. Prior to each session, a therapy session checklist (exhibit 2)

Exhibit 2: Therapy Session Checklist

Session date _____	Session date _____
Cocaine use _____	Cocaine use _____
Other drug _____	Other drug _____
SO _____	SO _____
Primary behavior	**Primary behavior**
_____	_____
Specific goals	Specific goals
_____	_____
_____	_____
Secondary behavior	**Secondary behavior**
_____	_____
Specific goals	Specific goals
_____	_____
_____	_____
Secondary behavior	**Secondary behavior**
_____	_____
Specific goals	Specific goals
_____	_____
_____	_____
Secondary behavior	**Secondary behavior**
_____	_____
Specific goals	Specific goals
_____	_____
_____	_____

is completed to ensure adequate preparation. The checklist provides the structure and guidance needed to stay focused on the task so that the treatment goals are covered in each session.

Session Protocol

The following protocol is followed for each session.

1. First, the therapist *reviews urinalysis results* (using the graph) with the patients and provides appropriate feedback. Any problems in the area of drug abstinence are discussed. Active listening skills are used to provide support, while encouragement and social reinforcement are used selectively to support the patients' efforts.

    - If the day's urine sample is *cocaine-negative*, patients are con gratulated and the behavior that helped them remain absti nent is discussed.

    - f the day's urine sample is *cocaine-positive*, patients are reas sured that cocaine use is their reason for being in treatment and that the treatment program is there to help with this prob lem. A functional analysis of the most recent cocaine use is conducted, and the therapist stresses the importance of un derstanding the reasons behind that behavior so they can bet ter learn to control their use.

2. The therapist then *reviews and evaluates progress on each treatment goal* . Graphs are updated and any problems are discussed. Active listening skills are used to provide support; encouragement and so cial reinforcement are used selectively to support patients' efforts.

3. If adequate progress is not being made, *problemsolving and appro priate behavioral procedures* are used to resolve any difficulties that may be interfering with achieving the targeted goals.

4. After reviewing progress in each problem area, *goals to be met by the next session are set*. Didactic teaching and rationales for new behavioral targets are discussed with the patient.

5. *Skills training, behavioral rehearsal, and role playing* are used as scheduled and when appropriate.

6. *Out-of-office procedures* can be implemented when warranted. For example, if the week's goal is to sample a recreational activity and the therapist is to function as the initiator, then the patient and thera pist go perform this activity. If the patients' goal was to fill out em ployment applications and they did not do so, then the therapist helps them do so during the session.

7. *Disulfiram compliance* is reviewed and evaluated with patients who are involved in that protocol. Any problems with the disulfiram therapy are discussed and procedures implemented to resolve such problems. Reinforcement and encouragement are provided for successful com pliance. Similarly, the compliance procedures for taking disulfiram at the clinic are followed with patients engaged in this protocol.

8. A *review of goals* to be accomplished between this session and the next, along with some words of encouragement, are the last things that happen in a session.

Recent Problems or Crises

Many cocaine abusers come to sessions each week with new or repeated crises. How the therapist handles such crises is important for the effective delivery of this treatment because CRA + Vouchers requires careful focus and structure. Certainly, ignoring patients' real life problems entails the risk that they will view treatment as irrelevant to their own needs, which may increase attrition. At least three options for handling crisis situations are available.

- Therapists can use their counseling skills to try to tie these seemingly unrelated issues back to the patient's treatment plan by discussing how the current treatment plan may help with the crisis.

- Therapists can discuss the importance of these issues while carefully explaining that these issues cannot be worked on until a period of abstinence has been achieved. If the strategies currently being tried are inappropriate or unsuccessful, a plan is discussed to better meet the patient's needs.

- Sessions are divided so that 10 - 20 minutes are available *at the end of a session* to discuss issues not directly related to the treatment plan. This strategy is an effective way to meet the patient's needs and retain the structured protocol. Importantly, the therapist can use at tention to the patient-specified issue as reinforcement for covering the session plan (the Premack principle). A statement like the follow ing can be very effective: "Yes, I can see why you are concerned about this matter. Let's try to get through some of our other issues so we can reserve time to talk about this." The order of events is impor tant here. Attention to the new concern must come after going through the planned activity.

If therapists feel that an intervention is necessary for the new concern, then a behavioral approach consistent with the structure of CRA + Vouchers is used to assist the patient. Referral to an outside source may be an option if the problem is clearly in need of immediate attention and is not tied to drug abuse. The clinical supervisor is consulted to help

resolve such issues. Trained therapists obviously must use their clinical judgment in dealing with such patient concerns. For example, one would not implement the aforementioned strategy in dealing with acute suicidality.

Special Issues

Absences

If patients do not come for a scheduled session or urinalysis test, an immediate attempt is made to contact them by telephone to find out why they missed the session. If patients do not have a telephone, a visit to their home is considered. Once contact is made, staff can encourage the patient to come to the agency right away. If necessary, transportation arrangements to the clinic are made. If this is not possible, the session is rescheduled as soon as possible. If patients cannot be reached for 2 days, an empathic letter of encouragement and concern is sent. All reasonable efforts should be made to retain patients in treatment. When patients return after an absence, problemsolving is conducted to prevent another similar absence.

Tardiness

Therapists should convey the attitude that sessions are important and patients should not waste time by being late. Assistance in helping patients solve any problems that contribute to tardiness should be offered. However, therapists should be careful to not punish attend-ance. Especially in the early stages of treatment, praise is offered for coming to the clinic even though late. If time is available, full sessions are conducted even if started later than scheduled.

Extra Sessions

Some patients will request extra sessions, particularly in the beginning of treatment. Therapists should try to meet such patient needs. Brief contacts can be scheduled or phone check-ins used to provide the additional support requested. The supervisor should be consulted to make decisions about how long additional support will be provided and how to handle more needy patients. Eventually, the goal is to reduce additional support and return to regularly scheduled sessions.

Note that by making a request, the patient is indicating that extra sessions are important (i.e., a potential reinforcer). Therefore, contracts could be written wherein the therapist agrees to extra meetings contingent on the patient completing certain goals.

Drug and Alcohol Use

Therapists should terminate any session in which patients are under the influence of alcohol or other drugs. This should be done in a caring but assertive manner. Therapists should explain that they are unable to provide the professional care that patients have requested when they

are under the influence. Patients are encouraged to return for the next session sober.

Concurrent Treatment

Patients should not be enrolled in other professionally delivered treatments for alcohol or drug problems while enrolled in CRA + Vouchers. Multiple treatments can cause confusion because different treatment approaches may use different strategies. Patients may get mixed messages or may be unable to focus their energies sufficiently to benefit from CRA + Vouchers if engaged in other treatments.

Attendance at AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) is often encouraged but not required. Some patients may choose to make self-help group attendance one of their lifestyle change goals, and therapists often recommend participation in AA or NA as a way to increase social interaction with sober individuals.

Treatment for other psychiatric disorders or behavior problems is often encouraged. An important judgment here is whether the problem directly influences cocaine use. If so, it must be addressed in the context of CRA + Vouchers or through an appropriate referral. Clinical judgment must be used to determine if the benefits of seeking additional treatment outweigh the potential for such treatment to distract from the focus of CRA + Vouchers. If the problem is mild and not directly affecting cocaine use, patients may be encouraged to postpone additional services so they can focus their energy on one problem at a time. Clinical supervisors should be consulted in these cases.

Premature Termination

Therapeutic termination and referral should be considered for those cases in which continued regular cocaine or other drug use places the patient in serious physical or psychological danger. During this time of HIV/AIDS and other fatal consequences of cocaine abuse, treatment dismissal should be made only after thorough and careful clinical assessment. However, when the therapist and other clinical staff feel they have exhausted their skills and efforts but the patient fails to progress, it is time for a referral.

Also to be considered are psychiatric reasons for termination and referral, such as acute psychosis or severe suicidal ideation that requires hospitalization. Possible termination always needs to be balanced against recognition that cocaine dependence is a life-threatening disorder characterized by ambivalence and risky behavior that can make progress in treatment difficult.

Therapists must guard against making referrals or dismissals merely because of noncompliance. Cocaine abusers are at continuous risk, and a mandatory referral or dismissal may exacerbate that risk if it results in

the patient not receiving any treatment. Such cases should be thoroughly discussed with the clinical supervisor and other staff.

The discharge of patients who stop attending treatment should be preceded by letters, phone contacts, and personal visits that convey a willingness to continue treatment or to provide referral options for treatment elsewhere. In the research on CRA + Vouchers, missing five consecutive scheduled urinalyses was a marker for termination from the program. This termination rule has never resulted in the discharge of a patient who wished to remain in treatment. Rather, it was used to provide a precise termination date for patients who simply stopped coming to treatment.

Documentation of Patient Contact

The following procedures are followed for documenting patient contacts.

- Intake assessment is completed within 2 weeks of first meeting.
- The treatment plan is completed within 1 week of the first meeting.
- Session notes are completed on the Progress Note form **(**exhibit 3**)** within 2 days of the counseling session. This form is designed to help the therapist stay focused on the treatment plan and to evaluate progress based on that plan. Note that the form is structured such that all aspects of the treatment plan are reviewed, active goals are speci fied, the measure by which to evaluate progress is designated, and progress is assessed each session.
- Notes from brief in-person and phone contacts are charted on the Brief Contact form **(**exhibit 4**)**.
- All professional contacts are charted on the Brief Contact form.
- Discharge summaries are completed within 2 weeks of discharge.

Clinical Supervision

Clinical supervision should be a component of this treatment for two reasons. First, CRA + Vouchers requires intensive services that target specific behavior changes. Unfortunately, many times CRA therapists may feel that they are working much harder than their patients. Patients may be noncompliant and refuse to follow through with many of the therapeutic tasks the therapists have worked so hard to set up. This scenario does not reinforce the therapists' hard work. Thus, it can naturally lead to a decrease in effort exerted by the therapist and foster

Exhibit 3: Progress Note

Patient:_____ Date:_____

Length of session: _____ Session: _____

Urinalysis:_____

_____ Urinalysis review
_____ Disulfiram review
_____ SO compliance review
_____ Collect Happiness Scale
_____ Record time spent

Problem Area	Goal	Measure(s)	Assessment
Status: A=Active; M=Maintenance; IN=Inactive; NP=No problem			
_____ Alcohol/Drug			
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
_____ Employment/education			
1.	1.	1.	1.
2.	2.	2.	2.
_____ Family/social support			
1.	1.	1.	1.
2.	2.	2.	2.
_____ Recreational/social activities			
1.	1.	1.	1.
2.	2.	2.	2.
_____ Psychiatric			
1.	1.	1.	1.
2.	2.	2.	2.
_____ Legal			
1.	1.	1.	1.
_____ Medical			
1.	1.	1.	1.

Homework:

Other comments: Changes in goals, missed sessions, schedule changes,etc.

Exhibit 4: Brief Contact Forms

Patient:_____ Date:_____ Length: _____
Type of Contact (circle one): Phone In person Other agency

Note:

Patient:_____ Date:_____ Length: _____
Type of Contact (circle one): Phone In person Other agency

Note:

Patient:_____ Date:_____ Length: _____
Type of Contact (circle one): Phone In person Other agency

Note:

Patient:_____ Date:_____ Length: _____
Type of Contact (circle one): Phone In person Other agency

Note:

Patient:_____ Date:_____ Length: _____
Type of Contact (circle one): Phone In person Other agency

Note:

negative feelings and pessimism concerning treatment. A supervisor who is not personally involved in administering the therapy can help the therapist remain motivated, creative, and positive.

Second, cocaine abusers enrolled in treatment have multiple problems, some directly related to cocaine and others that are not. Such patients often come to treatment sessions with a new crisis each week - some serious, others not so serious. These multiple problems and crises make it difficult for therapists to stay focused on the treatment plan. A supervisor can help therapists sort through these issues and can provide the structure, support, and encouragement to remain focused on the primary goal of treatment, cocaine abstinence.

The Voucher Program

The voucher program is a contingency-management procedure that systematically reinforces treatment retention and cocaine abstinence, the primary targets of CRA + Vouchers. Points are awarded for cocaine-negative urine test results, and the number of points is increased for each consecutive negative urine sample (exhibit 5). Failure to submit a scheduled specimen is treated as a cocaine positive. This procedure not only provides a reward for each cocaine-negative test but provides a greater incentive for patients who maintain long periods of continuous abstinence. Stable patients are better able to systematically work on the lifestyle changes targeted in the counseling sessions.

This system also recognizes that slips (use of cocaine) are highly probable during treatment. To discourage slips, the value of the voucher reverts to its initial value whenever cocaine use occurs. However, patients can regain the higher voucher values by providing five consecutive cocaine-negative specimens. Points already in the patients' accounts can never be lost.

Money is not provided directly to patients. Instead, vouchers are used to purchase retail items in the community by a staff member. Items obtained using the vouchers are quite diverse and have included ski-lift passes, fishing licenses, gift certificates to local restaurants, camera equipment, bicycle equipment, and continuing education materials.

Therapists retain veto power over all purchases. Purchases are only approved if, in the therapists' opinion, they are in concert with individual treatment goals related to increasing drug-free prosocial activities.

Objective Monitoring

Regular objective monitoring of cocaine and other drug use via urinalysis testing is an essential part of implementing CRA + Vouchers.

- Objective monitoring is necessary for fair and effective implementa tion of the incentive program and other behavioral contracts used in this treatment. Such contracts are only effective

Exhibit 5.- Recommended Reinforcement Schedule

Negative urine specimens earn points that are worth approximately $0.25 each.

During weeks 1-12 of treatment-

- The first negative specimen is worth 10 points or $2.50 ($0.25 x 10 points)
- For each subsequent, consecutive negative urine specimen, the value of the voucher increases by 5 points (e.g. second = 15 points or $3.75, third = 20 or $5.00, etc.)
- The equivalent of a $10 bonus is earned for three consecutive negative urines in a week.
- Positive specimens or failure to submit a specimen on schedule resets the value of vouchers back to the initial $2.50
- Five consecutive negative specimens after submission of a posi tive speciment returns the value of vouchers to their level prior to the reset

During weeks 13-24, the magnitude of the reinforcer is reduced to one state lottery ticket for each cocaine-negative specimen

if they are administered consistently and precisely. Reliance on self-reports would not be adequate for those purposes.

- By the time illicit drug abusers enroll in treatment, family, friends, employers, and others have often lost confidence in their veracity. Lying almost has to be part and parcel of regular involvement in illegal activities. Objective monitoring provides an effective means for patients to reduce suspicion and rebuild respect among their sig nificant others.

Objective monitoring keeps all interested parties, especially therapists, regularly apprised of the ups and downs in patients' efforts to resolve their drug abuse problem. Timely and objective evidence of patient progress is necessary for developing and revising treatment plans.

Urinalysis Schedule

Urine specimens should be collected from all patients under staff observation according to a set schedule (e.g., Monday, Wednesday, and

Friday during weeks 1 - 12 and Monday and Thursday during weeks 13 - 24.) All specimens should be screened for benzoylecgonine. Each week, one randomly selected specimen is screened for the presence of other abused drugs. Breath alcohol levels can also be assessed at the time urine specimens are collected. Patients and therapists should be informed of the urinalysis results as soon as possible after specimens are submitted.

The schedule is designed to optimize the probability of detection of cocaine use. Frequent testing allows detection of almost any use of cocaine. However, it may also result in multiple positive tests from a single cocaine use episode. This possibility cannot be avoided. Inform patients about this possibility at the start of treatment. Providing information about multiple positives in the beginning of treatment will greatly reduce controversy over the results or the fairness of the voucher system.

Specimen Collection

Staff members who collect urine specimens need at least bachelors degrees and should have received special instruction for several weeks by a trained staff person in the collection and analysis of urine. Adequate precautions must be taken to ensure against submission of bogus specimens. Some clinics have a same-sex staff member observe specimen collection; others monitor the temperature of the specimen. A written copy of the rationale and procedures for specimen collection should be provided to all patients before they enter the urinalysis component of the program.

After patients have read these materials, the staff member should ask if they have any questions and whether they understand these rules. Taking time at the outset to discuss the rationale and procedures for collecting specimens and referring to them while collecting the first specimen can prevent later confusion and problems. Patients who have any difficulty with these procedures should be asked to discuss their problem with the appropriate treatment staff.

Laboratory Analysis

Monitoring of cocaine use for clinical purposes can be accomplished by testing for the presence of the cocaine metabolite, benzoylecgonine, in urine. As a general rule of thumb, benzoylecgonine can be detected for up to 2 days following use of a psychoactive dose of cocaine. Longer intervals, up to almost 2 weeks, can result from use of high doses of cocaine. Because most specimens collected from patients enrolled in drug treatment are expected to be negative, immunoassays are recommended

or screening out negative samples (e.g., Braithwaite et al. 1995).

Because of cost and other factors, positive specimens are not regularly confirmed. Immunoassays for benzoylecgonine like the Enzyme Multiplied Immunoassay Technique (EMIT) are very specific; that is, there is little reaction with other compounds that might produce a positive result. Also, in the majority of cases, patients confirm the screens through self-reported cocaine use.

If your clinic policy is to regularly confirm positive specimens, experts recommend high performance liquid chromatography (HPLC) for clinical purposes and gas chromatography mass spectrometry (GCMS) for forensic purposes (e.g., Braithwaite et al. 1995).

Presenting the Results

Ideally, urine specimens should be tested immediately after collection while the patients wait. If you have a drug-testing system in your agency, and all testing is done by trained assistants, turnaround time can be very rapid (2 - 5 minutes). If your agency does not have laboratory capability, the results should be presented to patients as soon as possible.

To be consistent with the CRA + Vouchers model, staff should adhere to the following protocol when informing patients of their urinalysis results.

- Engage in pleasant conversation with patients while waiting for the results of the urinalysis.
- If the specimen is negative for cocaine use (clean), give the patients a voucher. Provide positive feedback to the patients and engage in positive interaction for a few minutes.

  " Good job, Jim. You're doing great. That's three in a row. How's work going ? Great, keep it up. What do you have planned this week end?"

- *If the specimen is positive for cocaine use (dirty), ask patients about the amount of cocaine used and on what day. Record this informa tion. Tell patients to speak to their therapist and immediately termi nate the conversation. This is very important. Do not engage in pleas ant conversation. Do not ask about what happened. Do not give thera peutic advice. Merely refer patients to their therapist.*
- *Inform the therapist of the urinalysis result as soon as possible.*

Intake

Any person who expresses interest in receiving help for a cocaine problem has taken a courageous step and should be treated accordingly. The therapist, intake worker, or receptionist who has first contact with a prospective patient should do everything possible to facilitate entry into treatment. Staff should provide timely assistance and be flexible in scheduling, empathic when appropriate, and optimistic about the patient's ability to change. Some cocaine abusers may present for treatment with poor attitudes or seem demanding. It is important to expect such negative behavior and to label it as part of the problem. This will help the therapist or intake worker provide the friendly, respectful, and flexible treatment access required.

Initial Contact

All initial contacts can be handled by a receptionist or clinician.

Screen Applicants

Conduct a preliminary screen to eliminate inappropriate applicants. For CRA + Vouchers , it is advisable to accept for treatment only those individuals who -

- Report cocaine abuse.
- Are aged 18 years or older.
- Reside within a reasonable distance of the clinic. This requirement is due to the intensive nature of the intervention. Patients are ex pected to attend the clinic a minimum of 3 days per week for urine monitoring and counseling during the first 12 weeks of treatment.

Schedule Intake

Once the applicant contacts the clinic to request treatment (either by telephone or by walking in), every effort should be made to conduct the intake interview as soon as possible. At least three studies show that scheduling intake appointments with minimal delay significantly reduces the attrition rate between initial contact and the intake appointment. Ideally, the intake would be done the same day; if that is not possible, then try to schedule it within 24 hours. The least accommodating

schedule should be within 2 working days of contact, although occasionally this process may take longer.

Inform eligible applicants that the first appointment takes approximately 3 hours to complete and explain what is involved.

- Completion of various staff- and self-administered questionnaires
- A brief overview of the program
- An initial meeting with a therapist to begin developing a treatment plan

Be prepared to be flexible on timing and scheduling. If the applicant cannot stay for the complete intake, schedule another appointment as soon as possible to complete the process. However, a brief introductory meeting with a therapist is recommended at the end of the initial intake session even if the intake needs to be completed in a second session.

If applicants bring a spouse or partner to intake, it is important to make the partner feel comfortable. However, the assessment interview is conducted with the applicant only. Prior to and after the assessment, inform the partner about the assessment and treatment process. If appropriate, raise the possibility of relationship counseling and encourage it at this time.

Intake Procedures

The intake session is one of the most important elements of the treatment process. This may be the first treatment experience for many, and they may feel uncomfortable or ambivalent about being there. Some patients may have had an unpleasant treatment experience in the past and are wary of treatment in general. It is important that patients are made to feel as comfortable as possible during the intake process.

- Be aware of the patient's potential uneasiness and do everything pos sible to make the initial meeting a positive experience.
- Convey positive, can-do messages. The applicant should clearly hear that, by working together, the applicant and clinic staff can resolve problems that brought the individual to treatment.
- Accommodate the need for brief breaks, food or drink, or need to make a phone call.

Assessment

It is important to collect detailed information on the severity of drug and alcohol use, treatment readiness, current psychiatric functioning, medical problems, employment, legal issues, and family and social problems. Following is a list of useful assessment instruments, in the order in which they are typically administered by the authors; your clinic may choose to use other instruments.

Self-Administered Questionnaires

The questionnaires described in this section are completed by applicants prior to the interview. If there is any question about reading ability, take the applicants to a private office and have them read several questions aloud to see whether they can complete the forms without staff assistance. Persons deemed capable of completing the forms should be given approximately 45 minutes to finish the ones described below.

If staff assistance is required, read the questions aloud in a private setting, with care and positive regard for the discomfort poor readers may feel under such circumstances. Reassure applicants that providing such assistance is not unusual, because many individuals are unfamiliar with the words used in such medical questionnaires.

- *Patient Information Form*

  A brief questionnaire should be used to obtain information on the demographic characteristics of the applicants as well as their current address and telephone number and the number of someone who will always know their whereabouts. This information can be used to contact patients who do not show up for treatment and to enhance followup efforts.

- *Cocaine Dependency Self-Test* and *Cocaine-Related Consequences Questionnaire*

  Adaptations of these forms can be used to efficiently collect useful, specific information about the applicants' pattern of cocaine use and associated problems (Washton et al. 1988).

- *Michigan Alcoholism Screening Test (MAST)*

  This widely used, 25-item instrument lists common signs and symp toms of alcoholism (Selzer 1971). Considering that most patients entering treatment for cocaine dependence also use alcohol, and greater than 50 percent meet diagnostic criteria for alcohol depen dence, the MAST is useful for flagging patients with alcohol prob lems.

- *Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)*

  This instrument provides information on applicants' perceptions of the severity of their drug abuse problem and their readiness to en gage in behaviors that reduce use (Miller and Tonigan 1996). It pro vides a quantitative index of motivation to change, which may be an important indicator of applicants' willingness to comply with certain treatment goals. Three versions of the SOCRATES that refer to spe cific substances (i.e., cocaine, alcohol, and other drugs) are adminis tered because the patient's motivation to reduce substance use is likely to be substance specific.

- *Beck Depression Inventory (BDI)*

  The BDI may be used to screen for depressive symptomatology (Beck et al. 1961). It can be easily readministered on a regular basis to monitor progress with patients who score in the clinical range at in take. The mean BDI score of cocaine abusers entering treatment typi cally falls in the clinical range of that scale. For most patients, BDI scores drop precipitously after 1 or 2 weeks of cocaine abstinence. However, that is not true for all patients. Therefore, it is important to carefully assess and monitor depressive symptomatology and to in tervene when symptoms do not remit.

- *SCL-90-R*

  This instrument may be used to screen for psychiatric symptoms to help determine whether a more indepth psychiatric evaluation is warranted. The SCL-90-R (Derogatis 1983) can be easily readministered to monitor progress or change in psychiatric status.

When the self-administered questionnaires have been completed, they are reviewed by the intake worker to make sure all questions have been answered. The information on the Patient Information Form is checked for completeness.

Program Description

A brief description of the CRA + Vouchers program and its philosophy should be offered after completion of the self-administered questionnaires but before the structured interviews. The goals are to -

- Orient applicants to what will happen in treatment.
- Create an atmosphere of optimism about treatment outcome.
- Make applicants feel hopeful about improving their life situation.

The intake worker should also explain that -

- The program is confidential; everything discussed or written remains private.
- The program is specifically designed for persons who have prob lems with cocaine.
- The program lasts 24 weeks, with the first 12 weeks being fairly intensive and involving counseling sessions at least twice a week and urine testing three times a week.
- If progress is being made, the last 12 weeks become much less inten sive. Counseling sessions focus on lifestyle changes designed to help patients make positive changes that will result in greater life satis faction.

The following is an example of a short description of what might occur during counseling.

> *"If you are interested in finding a job, the therapist will help you with the job search, with developing a resume, and with transporta tion and phone support if necessary. If you would like to go back to school, we can help you obtain the applications, access funding and assistance, and even take you to an interview if you need transporta tion. If you are having problems in your relationship, relationship counseling is available. If you don't regularly participate in any fun activities, we have many suggestions and may even take you to some of these, like basketball, tennis, fishing, boating, and arts and crafts classes."*

> *"We also provide coping skills training. If you have problems cont rolling anger, we can help with anger management. If you have money problems, we can assist you with financial management. If you have difficulty with behavior problems with your children, we can assist you directly or we can help you get some additional help. If you have trouble relaxing, we can work on relaxation skills and stress man agement."*

The intake worker also provides a very brief description of the Voucher program.

> *"You will also participate in our incentive program. When you pro vide cocaine-free urine samples, you earn points that can be used to support your goals. You can accumulate points to pay for activities like going to the movies, joining a gym, taking a class, buying a fish ing rod, and so forth. When you provide consecutive clean urines, you earn bonus points. Staying clean for 12 weeks can earn you the equivalent of nearly $1,000. Your therapist will tell you more about these things after our interview."*

After this brief description of the program, the intake worker should give applicants an opportunity to ask questions. Keep this interaction brief; the therapist can provide more detailed information after the structured interview is completed. If applicants are still interested and wish to enroll in CRA + Vouchers, escort them to a specified location to complete the structured interview.

Structured Interviews

- *Drug History*

  A structured drug history interview should be used to collect infor mation on past and current substance use to determine the duration, severity, and pattern of the patients' cocaine and other drug use. The accuracy of the patients' reports of cocaine use (amount and fre quency) is facilitated by the use of an effective technique for review ing recent use called timeline followback (Sobell et al. 1988). Using a calendar as a prompt, individuals are asked to recall, on a day-by-day basis, when they used a particular

substance in the past week and the amount used on each occasion. Grams are the best metric measurement for determining the amount of cocaine used. The same assessment is conducted for the previous 3 weeks and as far back as is needed for diagnostic purposes. This technique provides a good overview of the pattern of cocaine use during the past 30 days. The interviewer should ask for as much clari fication as possible to help obtain an accurate assessment of the ap plicants' substance abuse history.

- *The Addiction Severity Index (ASI)*

  This structured clinical interview is designed to provide reliable, valid assessments of multiple problems common among substance abus ers (McLellan et al. 1985). It gives a quantitative, time-based assess ment of substance abuse as well as employment, medical, legal, fam ily, social, and psychological functioning. The data obtained in this interview are useful for developing treatment plans that include lifestyle change goals. The ASI is also a useful instrument for assess ing progress at followup points because it is time based and yields quantitative composite scores for each problem area. Interviewers must be trained on ASI administration to ensure that they conduct a reliable ASI interview.

- *The DSM-III-R Checklist*

  Only the psychoactive substance use section of this semistructured interview is administered to facilitate accurate diagnoses of substance abuse and dependence (Hudziak et al. 1993). Special training in sub stance use diagnostics is required. Particular care must be taken to ensure accurate diagnoses, especially if a nonprofessional conducts the interview.

- *Practical Needs Assessment*

  This form (exhibit 6) was developed to determine if the cocaine abuser has any basic needs that may interfere with engaging successfully in treatment (e.g., housing, legal, transportation, childcare, financial). The interviewer asks specific questions and collects detailed infor mation on each area of potential need. These are needs that may re quire immediate attention and should be given priority in treatment planning, since many cocaine abusers enter treatment with their lives in chaos. The probability of engaging and keeping patients in treat ment may be compromised if swift attention is not provided to basic life problems.

After the interviews are completed, the intake worker should inform the ap-plicants that they will be meeting with their therapist in a few minutes, after a brief break (5 - 10 minutes). The intake worker should then complete an intake summary sheet (exhibit 7) and give it and all

Exhibit 6: Practical Needs Assessment

Housing

- Does the patient have a place to live?
- Is it satisfactory?
- Does it place the patient at risk for cocaine use?
- Does the patient have a phone?
- Are there utilities in service?
- Is any type of housing assistance needed?

Employment

- What is the patient's employmeny status?
- Is this employmeny satisfactory?
- Is cocaine use a risk on the job?
- What services can be used to improve the situation?

Financial

- Is the patient in trouble financially?
- Is the patient in need of financial counseling?
- What financial services are needed?

Education

- Would the individual benefit from additional education?
- Is the patient interested in obtaining more education?
- re the patient's expectations realistic?

Health

- Does the patient have adequate health care?
- Is the patient or the family in need of health services?
- What health services could the patient use?

Legal

- Is the patient in need of legal assistance?
- What type of legal services would be helpful?

Childcare

- Does the patient need childcare services?
- What type of childcare would be helpful?

Transportation

- Does the patient need transportation services?
- What type of transportation would be helpful?

Assessment

List the areas/and or services that would benefit the patient.

_____
_____
_____
_____
_____

Exhibit 7: Intake Worker Summary

Patient _____ D.O.B. _____ Date _____

1.Current Drugs Used (list): _____

2.Referred by: _____

3.Presenting problem according to patient: _____

4.Drugs patient wants help with: _____

5.Pattern of use over last 6 months: _____

6.Current DSM-III-R drug dependence (list): _____

7.Current DSM-III-R drug abuse (list): _____

8.Current DSM-III-R dependence/abuse : drug yrs used route pattern of use last 6 months (daily, w/friends, etc.)

_____

_____

_____

9.Past DSM-III-R dependence/abuse (list): _____

10.Prior drug abuse treatment (list date/type): _____

_____

11.Employment (circle one): full part-time unemp.; type of work _____ pattern last year:_____

12.Education completed (specify grade, Assoc., B.A., Voc. training): _____

13.Marital status (circle one): single married divorced widowed live-in partner

14.Children (circle one): yes no; ages: _____

15.Current living situation (list persons in home): _____

_____

16.Legal status (ASI): _____

Was entry into program forced through legal situation? yes no Is legal status related to drugs? yes no

17.Medical issues (ASI): _____

18.Psychiatric issues (ASI): Suicidal thoughts (circle one): yes no; Past attempts: _____

19.MAST Score: _____ 20.BECK score _____

21.ASI Scores: _____ Alcohol:_____ Drug: _____ Medical: _____ Legal: _____ Fam/Soc: _____ Psych: _____

of the intake information to the therapist during a brief meeting to review the case. Patients are then introduced to their therapist.

Initial Treatment Session

The purpose of the initial treatment session is to ensure that patients leave the clinic feeling that treatment has begun and there is hope that they can improve their life situation. In many ways, this is an orientation session (exhibit 8). The session should be used to establish rapport with the patient and to provide a clear rationale for the CRA + Vouchers approach. By doing this, patients will develop clear expectations about how treatment works and about what is expected of them.

If the patient is pressed for time or tired from the intake procedures, this first meeting with the therapist can be shortened and any unfinished business completed in the next session. The most important goals of this meeting are to build rapport, enhance expectations, and orient patients to the treatment process.

Get to Know the Patient

Therapists should begin by introducing themselves and reviewing the purpose of the session.

> *"What I hope we can do is begin to get to know each other. I'd like to start by briefly discussing the problems that brought you here. I know you already discussed them in detail with the intake worker, but I'd like to hear about your problems from you firsthand so I can get a better feel for what's going on. Then I'd like to give you an idea of what to expect as far as your treatment goes. Please feel free to ask questions or express any concerns you may have about the treatment or any thing else. Hopefully, by the time we're done, you will feel like we have a chance to really help you with your problems. How does that sound?"*

Expressions of empathy and support from the therapist for the patient's situation are essential during this session. The intake information is used to guide questions and express concern. The therapist can ask for clarification of any information on the intake materials as a means of further understanding the patient's problems and clearing up any ambiguities.

Therapists start this process by inquiring about drug and alcohol use and associated problems.

> "I can see by looking over your paperwork that you have come to the right place. It looks like problems with cocaine use and to some ex tent alcohol use are the primary problems. Is that right? . . . Can you tell me a little bit about your cocaine use and how it led you to seek help today? . . . I see you had some treatment in the past. Was it helpful?

Exhibit 8: Goals for the Initial Treatment Session

- Get to know the patient
- Provide an overview of and rationale for this treatment.
- Initiate the vouchers program, including the abstinence contract.
- Develop the problem list.
- Review the practical needs assessment.
- Provide an appointment book.
- Discuss the role of significant others in the treatment.
- Initiate disulfiram procedures, if needed.
- Make sure a urine sample has been collected.
- Schedule the next session.

. . . What did it involve? . . . What do you expect to get out of treatment this time around? . . . Are you optimistic about your chances for success? . . . Do you have any thoughts about what it will take to get you to stay clean? . . . Tell me a little about the pros and cons of your cocaine use. What are the positive aspects of using? What are the negative aspects?"

Next the therapist moves to a similar mode of interviewing regarding other problem areas.

"I see you do construction work. Is that full time? . . . How do you like it? . . . Are you satisfied with that type of work as a way of making a living?. . . Are there other types of jobs you are considering? . . . Does your current job pose any risks for using cocaine or drinking? . . . Do you use drugs with your coworkers? . . . Are you interested in finding another job or getting any additional training? . . . Do you have a timeframe in mind for when you might do that? . . .

"I see that you are married and have two children. How old are they? How are they doing in school? . . . Any problems or concerns with either of them? . . . Does you wife agree with you about that problem? . . . Have you tried anything to help with that? . . . How did it work? . . . How are you and your wife getting along? . . .That's too bad. It's pretty common for us to hear about those types of problems in this clinic. Is she willing to work with you on your cocaine problem? . . . If she is, we'd love to have her come in. I'll tell you about how that might work in a few minutes."

This type of questioning will promote a discussion and provide an opportunity for therapists and patients to exchange information relevant to treatment planning. Therapists can also assess the patients' general level of functioning, gain an initial understanding of their history, and assess their attitudes toward treatment.

Provide Overview and Rationale

After reviewing the intake material and touching on the specific problem areas, the therapist should explain the philosophy and goals of CRA + Vouchers. The overview should be phrased in a positive, confident manner and draw on the empirical support for this approach in the treatment of cocaine dependence. The therapist should describe how the treatment experience gives patients an opportunity to move their lives forward in a positive and fulfilling direction. The therapist should be upbeat and optimistic when presenting the overview. The overview includes the following.

> *"I'd like to tell you a little bit about the treatment you will be receiv ing. This treatment can provide you with skills others have found useful for overcoming cocaine abuse. Our main emphasis will be on -*
>
> - *Getting you involved in new social and recreational activi ties.*
> - *Beginning new employment or educational opportunities if you want.*
> - *Helping you obtain more satisfaction from relationships with family and friends.*
>
> *"We have learned that, for people to stop cocaine abuse, they must make significant changes in their lifestyle. Cocaine and other drug use can develop a very powerful control over a person's life. To stop using drugs and alcohol, people must have something equally pow erful to look forward to that will fill their time. That is why our focus will be on helping you increase the satisfaction you get from things in your life that have nothing to do with drugs or alcohol. We believe that nondrug-related activities can compete against the powerful ef fects of cocaine use and the activities associated with its use.*
>
> *"Our program also provides incentives for you to abstain from co caine. I'll explain how that works in a few minutes. We will also focus on teaching you effective ways to avoid relapse and to turn down drugs when they are offered to you. We know that slips can occur while you are in treatment, but that is no excuse for quitting treatment. Ups and downs can be expected. However, we are not giving you permission to use."*
>
> "One important factor to keep in mind is that there are usually mul tiple causes of cocaine abuse. Some people say it is genetic, others say one's family or the stress of our society is the cause, others say it is like a disease, while still others say it is a learned habit that can be unlearned with practice. It actually doesn't matter how the problem

got started. Once it exists, we must look at what needs to be done in the here and now to solve the problem. Whatever the causes, it doesn't help to blame anything or anyone. We have to focus all our attention and energy on the lifestyle changes that need to happen for you to stop using cocaine."

"We will help you to the very best of our ability. It will be hard for all of us and I expect some tough times. We will be there for you during the good and bad times; we will help you understand your cocaine abuse and help you develop alternative activities. However, nobody can change your life for you. We can and will try to assist you in every way we can, but you will have to do the work of changing your life."

Introduce the Voucher Program

Describe Abstinence Contract

After describing the treatment program, the therapist should answer any questions the patients may have and then introduce them to the notion of therapeutic contracts via an abstinence contract. This involves a written contract in which patients explicitly agree to abstain from cocaine use and to conform to a regular schedule of urinalysis testing. The rationale for this contract is based on the primary treatment goal of eliminating cocaine use. **Exhibit 9** is an example of a contract adapted from one reported by Crowley (1984).

Explain Urinalysis Monitoring

Urinalysis monitoring is used as an objective marker of progress in achieving the goal of abstinence from cocaine. It is imperative that patients clearly understand the rationale for this procedure, and it is the responsibility of clinic staff to ensure that they understand. Below is a list of reasons for using a urinalysis monitoring contract. These are shared with patients.

- Urinalysis monitoring contracts have been used successfully to help decrease many forms of drug use, including cocaine, opioid, and ben zodiazepine use.
- Urinalysis monitoring will help us stay focused on the primary prob lem that brought you into treatment. We are not trying to catch you being bad, but rather to catch you being good (i.e., not using co caine). In this way, we as well as others in your life can reinforce this desired behavior. We can provide incentives, praise, and other forms of positive support when you don't use drugs. In addition, urinalysis monitoring will assist us in helping you learn more about the rela tionship between cocaine and other drug abuse and certain conse quences.
- If you use cocaine during treatment, the urinalysis test will provide us with that information and an opportunity to work on ways to help you get back on track and prevent further use from occurring. Many times, patients do not want to share the fact that they used cocaine because of embarrassment, pride, or some other reason;

however, such information is important for helping you learn more about how to meet your goal of stopping cocaine use.

- Many times, drug abusers have lost credibility with friends, rela tives, and other persons in their lives by the time they arrive in treat ment. Urinalysis monitoring can provide a way to prove that you are doing well. This may be important, because once you start doing well, any bad days or irritability may be perceived by others as an indication of relapse. Urinalysis monitoring can provide reassurance to those around you that you are continuing to do well. Thus, moni toring can assist you in regaining credibility with family and friends.

Explain Voucher Program

It is imperative that the therapist take adequate time to discuss the rationale and procedures related to the voucher system in the introductory session. The following issues should be covered.

- Purpose.

  "The purpose of this incentive system is to give you a positive re ward for staying in treatment and achieving your goal of not using cocaine. It is also a way to increase your motivation to work hard on this goal and to support you as you work toward making some of the lifestyle changes important for increasing your life satisfaction and maintaining cocaine abstinence."

- Examples of how to use earnings.

  "The points you earn can be used to pay for things like taking a person who does not use drugs to the movies or dinner but not to a bar or party. The points can be used to take classes or get training in some area that you would like to pursue as a career or hobby. The points can be used to pay to develop regular hobbies or activities like joining a gym, the YMCA, or dues for a photography or hiking club. They can also be used for family activities like taking a child for swimming lessons, to a State park, or to an amusement park. With the approval of your therapist, any activities that promote healthy behavior rather than drug use can be considered."

- How the points accumulate.

  "The point system is designed to help you maintain periods of con tinuous cocaine abstinence. The points increase each time you pro vide a cocaine-free urine specimen. For example, the first clean urine specimen you provide is worth $2.50 in points, the second $3.75, and for each week with three consecutive cocaine-free samples, you will receive bonus points worth $10.00. Thus, if you were clean for 6 consecutive weeks, one clean sample provided during Week 7 would be worth $25.00. All in all, if you stay clean every week for your first 12 weeks in treatment and provide all urine specimens as scheduled, you will have $997.50 worth of points that can be spent.

EXHIBIT 9.- Sample Abstinence Contract

This is an agreement between _____(the patient) and _____(the therapist) to help the patient maintain abstinence from cocaine. By this agreement, I direct my counselor to establish a schedule for collecting urine specimens from me for 24 weeks. I will provide urine samples three times each week on a Monday, Wednesday, and Friday during the first 12 weeks of treatment. During the second 12 weeks of treatment (weeks 13-24), urine samples will be collected two times each week on a Monday and Thursday schedule. A clinical staff member of my same gender will observe the urination. Half of each urine sample will be submitted for immediate analysis and half will be saved at the treatment agency. Samples will be assayed for a variety of drugs of abuse, including cocaine, amphetamine, opioid drugs, marijuana, and sedatives.

Each specimen collection requires 3.0 ounces of urine. If the quantity is insufficient for analysis, that will be considered a failure to provide a scheduled sample.

If I travel out of town because of an emergency, I will inform my counselor in advance of leaving. My counselor is authorized to verify such absences with _____. I If I require hospitalization, my counselor will arrange to collect urine in the hospital. If I am sick and do not require hospitalization, I will still arrange to produce scheduled urine specimens. If I have difficulty with transportation, or inclement weather makes it difficult to travel, I will work out (with the assistance of the clinical staff) a way to get to the treatment agency. On certain major holidays, the agency will be closed. My counselor and I will mutually agree to altered urine schedules on those occasions.

If, for appropriate medical reasons, a prescription is written for a medication that is sometimes abused, I will supply my counselor with copies of that prescription. The appearance of that drug in the urine will not be counted as a relapse to drug use. I hereby direct my counselor to communicate by mail or telephone with the prescribing physician or dentist when my counselor deems that action to be appropriate.

Cocaine-Free Urines: For each cocaine-negative urine sample collected during weeks 1-12 of treatment, points will be earned. Points are worth the monetary equivalent of $0.25, although they are not exchanged directly for cash. A voucher stating the earned point value will be presented to me following the collection of a cocaine-negative sample. This voucher will specify the number of points I earned for that day, as well as the cumulative points earned to date and their monetary equivalent.

During the first 12 weeks of treatment, the first cocaine-free urine sample will earn 10 points. Each consecutive cocaine-free sample collected thereafter will earn another 5 points above the amount earned before. For example, if 10 points are received on Wednesday for a cocaine-free urine sample, Friday's cocaine-free sample will earn 15 points, Monday's will earn 20, and so on. As an added incentive to remain abstinent from cocaine, a $10 bonus will be earned for each week of three consecutive cocaine-negative urine samples collected at the agency. Assuming there are no cocaine-positive urine samples collected, the monetary equivalent of $ 997.50 can be earned during the first 12 weeks of treatment.

(continued)

Since a major emphasis in the program is on lifestyle changes, primarily increasing activities that effectively compete with drug use, the money earned on this incentive system must be used toward social or recreational goods and activities agreed upon by myself and my counselor. A list of acceptable uses of vouchers has been developed for this purpose and will be given to me. During the second 12 weeks of treatment, the incentive program will be changed. Rather than earning vouchers for cocaine-negative samples, I will be earning lottery tickets for clean samples.

For the entire 24 weeks of treatment, immediately after the urinalysis test results indicate that the urine sample is cocaine-negative, the vouchers (weeks 1-12) or lottery tickets (weeks 13-24) will be delivered. Following the presentation of each voucher, I will be asked if I would like to purchase any goods or services. Vouchers may be used at any time during the program. Earned vouchers cannot be taken away from me under any circumstance.

Cocaine-Positive Urines: All urine samples will be screened for drug use. A record will be kept of all drugs screened positive, although this contract will be in effect for cocaine only. For each cocaine-positive urine sample collected, I will not receive a voucher. In addition, the voucher earned for the next cocaine-free urine sample will be reset to 10. To reset the voucher value to where it was prior to the cocaine use, I must provide five cocaine-free samples in a row. The fifth clean sample will then earn me the same monetary equivalent as that earned for the sample preceding the cocaine-positive one, and the system outlined above will continue to be in effect (i.e., each clean sample will earn 5 points more than the previous one).

Failure to Provide a Urine Sample: Failure to provide a urine sample on the designated date (without prior approval of my counselor) will be treated as a cocaine-positive sample, and the procedures noted above will be in effect. Although the clinic may attempt to obtain the sample by coming to my home (with my permission), cocaine-negative urine samples collected in this manner will not earn voucher points, nor will they reset my voucher value to 10. In effect, cocaine-negative samples collected outside the treatment program (except in the case of hospitalization) are neutral. If a sample is obtained from me outside of the program, and the sample is cocaine-positive, it will be treated in the manner outlined above for cocaine-positive urine samples.

My signature below acknowledges that I agree to the urinalysis monitoring system outlined above. This system has been carefully explained to me, and I understand the outcome of providing both cocaine-negative and cocaine-positive urine samples while I am a patient at the clinic.

Patient: _____

Therapist: _____

"In this system, however, one cocaine use during the middle of treat ment can cost you quite a few points/dollars. For example, if you are clean for 8 weeks and then, during Week 9, you use cocaine, instead of getting $32.50 for the next clean urine sample, you get only $2.50. And instead of the next clean urine sample being worth $33.75, it is only worth $3.75. You can see the system is designed to help you stay clean for long continuous periods. However, because we recognize that cocaine use during treatment may occur, there is also a proce dure to encourage you to stop using if you do slip. If, following a slip, you provide five clean samples in a row, the value of your vouche rs returns to the level of points you would have achieved before the slip."

Review Abstinence Contract

After answering any questions about urinalysis and vouchers, therapists can hand patients an abstinence contract and ask them to follow along as they read it aloud. Questions should be elicited from the patients, and therapists should provide as much explanation as necessary. It is essential that patients completely understand this contract, including the urine sample collection schedule, reinforcement schedule, and process of voucher spending.

Priming

After reviewing the abstinence contract, all patients are provided with two movie tickets or passes to some community recreational facility such as the YMCA or YWCA. These incentives serve as a start toward having the patient engage in lifestyle changes deemed important for treatment success. These passes are *not* contingent on a cocaine-negative urine specimen.

This procedure is called priming. It should be explained as an example of what can be done with the vouchers earned for cocaine abstinence. Therapists should also use this as an opportunity to have patients begin the process of planning and scheduling cocaine-free activities by discussing when and with whom they plan to use the passes.

Therapists should make sure patients receive the passes before leaving the clinic.

Problem List

Next, therapists can switch the topic to the development of a treatment plan. The problem list **(exhibit 10 and exhibit 11)** can help organize the areas that will be worked on during treatment. Therapists should explain that the list focuses on seven areas of life functioning:

- Drug and alcohol use
- Employment and support status
- Family relationships
- Social and recreational functioning

Exhibit 10: Problem List Form

Date: _____ Patient:_____

Problem 1: **Drugs/Alcohol**

Problem 2: **Employment/Support**

Problem 3: **Family**

Problem 4: **Recreation/Social**

Problem 5: **Psychological**

Problem 6: **Legal**

Problem 7: **Medical**

Exhibit 11: Sample Problem List

Date: 3/8/98 Patient: Jim

Problem 1: **Drugs/Alcohol**

Cocaine Use. Intravenous. 3x per week. Spends $250/week on cocaine
Drinks 6 beers about 4-5x a week. Drinks more when doing cocaine. DWI 2 months ago
Marijuana use daily. 1-2x per day, usually in the evening after work

Problem 2: **Employment/Support**

Works construction job - irregular full time, work declines in winter and sometimes other times.
Pay is fair - not enought to support family well.
Most guys on the job use alcohol and drugs.

Problem 3: **Family**

Wife always angry at him for spending money and coming home high.
Doesn't spend much time with his children.
Loses his temper frequently and yells at wife and children.

Problem 4: **Recreation/Social**

No regular prosocial activities. Most friends are drug users.
Likes to work out frequently.

Problem 5: **Psychological**

Depressed mood.
Irritable most of the time.

Problem 6: **Legal**

DWI - on probation.
Assault charge - on probation.

Problem 7: **Medical**

Positive for hepatitis B and C.

- Psychological status
- Legal status
- Medical status

Data from the intake assessment can be used as a guide during this discussion. (If the ASI is used, it assesses each of these areas.) Therapists can elicit from patients the problems that they are experiencing in each area. After this discussion, most of the important problems should be identified. This information can then be used in developing the patients' treatment plans.

Practical Needs Assessment

Therapists should also review the information on the patients' Practical Needs Assessment forms, which focus on such areas as housing, childcare services, and transportation needs. Reviewing these areas with patients will follow naturally from the data on the problem list. Any significant problems that might impede treatment compliance or success should be targeted for intervention as soon as possible. For example, helping homeless patients find at least temporary shelter would be an immediate priority. If they do not have transportation or a ride to the treatment facility, transportation issues should be discussed.

Hopefully, therapists can initiate some problemsolving and action as soon as these types of issues are identified.

> *"You say you live about 5 miles from the clinic and don't have a driver's license. Is there a bus route that goes near your home? . . . No . . . Can your wife drive you here regularly? . . . She doesn't have a license either. . . . Do you have friends or relatives who drive who are not active drug users? . . . Your sister? Can she give you a ride? Why don't we call her up and check it out? . . . It's possible that if she can drive 2 days a week, maybe we can help you with a ride on the other day. What do you need to do to get back your driver's license? Have you filled out the reinstatement application? . . . Why don't we call the DMV now and have them send us an application? If we can figure out how to come up with $50.00, we could get you back your license as soon as next week."*

Assisting patients very early with problems like these can help tremendously with treatment compliance in general. This type of aid also gives therapists credibility as people who understand patients' basic needs and can help make things happen to change their lives.

Appointment Book

Patients should be given a pocket-sized daily appointment book, and the importance of scheduling activities and appointments should be discussed. The rationale provided to the patient is that the goal of the program is to develop new habits that include regularly scheduled

activities that are not related to drugs. Planning and scheduling those activities is the best way to develop new habits.

Therapists should also stress the importance of bringing the appointment book to the clinic for each therapy session. It can be a valuable tool in helping patients stay focused on the behavior changes that are the core of CRA + Vouchers. Therapists should continually emphasize this point and prompt patients to bring it to all sessions.

Significant Others

If patients are involved in a relationship with a partner, discuss the possibility of relationship counseling and its potential benefits. A brief description of the content and structure of the counseling should be provided. If patients agree, schedule an appointment for the first relationship counseling session. If partners have come to the clinic for this initial session, therapists should discuss with them their potential role in treatment and the benefits of participation.

Disulfiram Procedures (if applicable)

Those patients who show evidence of alcohol abuse or dependence, or who report that alcohol use interferes with cocaine abstinence, should be offered disulfiram therapy. For example:

> *"You have indicated a few times today that your drinking causes you problems and that you always use cocaine when you drink. This is a fairly common experience among our patients. Because of this relationship between cocaine and alcohol, we feel that it is very useful and sometimes necessary for people with cocaine problems to stop drinking. Staying free from alcohol allows you to have a clear head, which you will need to resolve the difficult problems of stopping cocaine use. Many times, if someone doesn't stop drinking, they find that even though they have good intentions of staying clean from cocaine, they fail. Once they have a few drinks, their plans go right out the window and they use cocaine."*
>
> *"We have found that an effective way to help people stop drinking is by using a medication called disulfiram. Have you heard of it? . . . We find that those patients who take disulfiram are much more likely to achieve their goal of cocaine abstinence."*

Try to get patients who need this medication started on disulfiram in a timely manner.

Collect Urine

The therapist should make sure that a urine sample has been collected before the patient leaves the clinic.

Schedule the Next Session

Before the patient leaves the clinic, the therapist should schedule the next session. Every effort should be made to hold the meeting as soon as possible. The next day is preferable.

Early Counseling Sessions

Sessions One and Two should take place as soon after the intake meeting as possible. It is essential to complete the assessment/orientation and start treatment while patients are motivated. Therapists should be flexible and willing to schedule these early sessions at any time that is compatible with the patient's schedule. Prior to these two sessions, as with all sessions, therapists should prepare by completing a therapy session checklist.

Outline a Treatment Plan

Prior to Session One, therapists should begin to develop a tentative treatment plan **(**exhibit 12**)** using the information collected during intake. The final working version of this plan, however, should represent active collaboration between the therapist and patient. It is important that patients be involved in this process and that they agree to the goals and methods.

Achieving cocaine abstinence is always the primary focus of the treatment plan. Thus, the plan should target areas for change that are directly related to cocaine use, are likely to decrease cocaine use, or will reduce the probability of relapse. Areas for change typically fall into the following categories: other drug use, vocation, family relations, social relations, and recreational activities. Psychiatric, legal, medical, financial, or housing problems deemed likely to interfere with achieving or maintaining cocaine abstinence should also be considered.

The following steps are useful in this task.

- Develop a list of lifestyle changes that are reasonable targets for the patient.
- List reasons for those changes that can be readily discussed with the patient.
- Prioritize targets for lifestyle change based on what is most urgent for achieving initial cocaine abstinence. It is important to decide on the order in which such changes should be attempted.

- Determine methods for achieving change in each of the targeted ar eas. For example, if the goal is to find satisfying employment, the method might be employment counseling, resume building, and so cial skills training. If the goal is to enhance patients' relationship satisfaction, the method would be relationship counseling and com munications training. If the goal is to increase prosocial recreational activities with nondrug-using peers, the method might be social/recr eational counseling, and social skills, relaxation, and time-manage ment training.

Our research and that of others indicate that alcohol use and abuse are often major obstacles to achieving cocaine abstinence. Hence, we routinely recommend a period of disulfiram therapy for all patients who meet diagnostic criteria for alcohol abuse or dependence or who report that drinking is related to their cocaine use.

Sessions One and Two

Therapists have a great many tasks to accomplish in Session One as well as getting to know the patient better and developing rapport. It is unlikely that all of these tasks can be completed in one session. Those that are not should be carried over into Session Two.

- Review the patient's urinalysis results since the last meeting.
- Complete anything not accomplished in the intake assessment ses sion and review the rationale for behavioral treatment.
- Introduce the concept of functional analysis of cocaine use and stimu lus control procedures to help with initial abstinence.
- Assist the patient with practical needs.
- Use the patient's appointment book to organize, plan, and schedule activities.
- Initiate or continue with disulfiram or relationship counseling proce dures.
- Begin to develop the treatment plan.

Urinalysis Results

Therapists should review the urinalysis results with the patient and provide appropriate feedback. (The voucher should have been supplied by the staff person who reports the results to the patient.) Any problems in the area of drug abstinence should be discussed.

Complete Intake and Treatment Orientation

Patients should complete any unfinished assessment instruments or interviews. If this is all the patients have time for, they should still meet with their therapist. If time is limited, therapists should answer any new

questions that the patients have and offer some optimistic remarks about treatment outcome.

Introduce Functional Analysis and Stimulus Control

In the early stage of treatment, it is important to teach patients to identify the antecedents of their cocaine use so that they can actively prepare to deal with situations that place them at high risk for drug use. We refer to this as functional analysis.

The therapist should provide an overview of functional analysis and stimulus control procedures to help the patient understand how these can be used to avoid or actively cope with risky environments. In this context, the notion of craving should be addressed. The following points should be made.

- Having the urge or craving to use cocaine is normal for persons in treatment for cocaine dependence.
- These urges can be triggered by external environmental events or internal states. Examples of external events are seeing a friend you have previously used with, passing a certain bar, watching a TV show about cocaine, or attending a party. Examples of internal states may be memories of past use episodes, feelings of depression, nervous ness or tension, or remembering the good effects of past uses.
- Urges to use are time limited; they only last a few minutes or at most a few hours. They usually become less frequent and less intense as you learn how to cope with them.
- Functional analysis is the procedure by which you learn to identify triggers for craving and cocaine use so you can develop strategies to avoid or prevent them from occurring and cope with urges if they occur.

Therapists will probably not have time in Session One to fully introduce and explain functional analysis. Before this session ends, however, therapists should discuss potential triggers (e.g., high-risk situations) that may occur before the next session and help patients develop strategies for dealing with those situations. Concrete plans should be made to deal with these high-risk situations before patients leave the clinic.

Assist With Practical Needs

If practical needs such as housing or transportation are issues for treatment attendance, these needs should be a primary focus of the first session. Therapists should do everything possible to assist patients in finding solutions to these problems.

Use the Appointment Book

Have patients use the appointment book provided by your agency to schedule alternative activities or strategies for coping with high-risk periods or situations. The next session should also be scheduled, and patients should record the day and time in the book.

Start To Develop the Treatment Plan

It is unlikely that a comprehensive treatment plan with specific goals and methods can be completed in Session One. Nonetheless, the topic should be introduced at the first opportunity. The therapist might say something like the following.

> *"A treatment plan will allow us to write down the things you and I think are important to accomplish and how we plan to go about trying to accomplish them. We will use the plan to keep us focused on the task at hand, that is, making lifestyle changes that will help you stop using cocaine and other drugs and also increase your satisfaction with other important areas of your life. The treatment plan will be developed through a cooperative effort between you and me. It is important that you think the goals we set are important and will help you achieve what you want in life. My job in this process is to assist you in coming up with meaningful, effective goals and to offer advice based on my knowledge and experience with treating persons with cocaine and other drug problems."*

Discuss Areas for Change

Therapists should then present their ideas about which areas of the patients' lives need changes. For each suggested change, it is important that the therapist provide a rationale that draws from the information collected from the patient as well as from research findings and clinical experience. An open discussion and exchange of ideas should then follow.

If patients are reluctant to participate, the therapist should prompt them for their thoughts on each issue. To facilitate patient input, the therapist should use phrases such as: What do you think? Do you have any thoughts on this? Does this make sense to you? Do you think this is important? Is this type of change possible?

It is important for therapists and patients to agree on which areas of life present problems and should be changed. If patients disagree with the therapist's opinion, those areas should be dropped for now and discussed later in treatment if they continue to pose problems.

Prioritize Problems

Next, therapists and patients together decide the order in which these problem areas should be addressed, always remembering that increasing cocaine abstinence is the primary goal. Mutual agreement is important, and the therapist may need to compromise to achieve such agreement.

Set Specific Target Goals

Specific goals should then be set for each problem area. It is important that therapists provide the rationale for setting specific goals.

> *"Setting specific goals is important. They will help us stay focused on the primary changes which we agreed are important for stopping drug use and achieving a more satisfying life without drugs. Specific goals also provide a way to measure progress. This can be very im portant, because many times progress can be slow. You may feel you are getting nowhere. In reality, you may be progressing and making changes, but you don't feel much different. Information about spe cific goals will help us both see more clearly whether we are heading in the right direction, even if the progress is slow."*

> *"This information could also show when you are not progressing as we planned. This information could lead us to either reconsider the goal or find other ways to meet the goal. Keeping track of progress on spe cific goals also provides us with a reminder to reward or praise you for the hard work you are doing. Lifestyle changes are often dif ficult to make. We would like you to learn to pat yourself on the back and take credit if you are doing well."*

These goals should be quantifiable so progress can be graphed. Targets for change should be set in the priority areas listed in the treatment plan and categorized as primary or secondary behavior change goals.

The *primary behavior* goal in most cases will be one that emphasizes change in the highest priority area. Examples of typical goals might be -

- Five job contacts per week or making an appointment with voca tional rehabilitation if the patient is unemployed.
- Engaging in three recreational activities each week during high-risk times.
- Spending 4 hours each week engaging in fun activities with a family member or close friend.
- Attending class one night each week.
- Doing 2 hours of homework toward obtaining a GED.
- Planning and following through with activities with a nondrug user on nights cocaine is typically used.

Secondary behavior goals might include similar behavioral changes, but they would not have the highest priority for achieving and

maintaining abstinence for that particular patient. A maximum of three secondary behavior changes should be targeted.

Therapists and patients should mutually decide on these goals. Basic principles of effective goal-setting should be followed.

- Set goals relatively low at first so the patient can experience success early in treatment.
- Thoroughly analyze all possible barriers to achieving selected goals so that unrealistic goals are not chosen.
- Make sure the patient understands how a goal relates to the overall treatment plan.

It is essential to maximize the probability that patients will carry through and achieve the desired behavior change. The therapists' responsibility is to use the appropriate counseling style and behavioral procedures to increase the probability of compliance with a targeted behavior. The graphs of patient behavior are especially useful because they visually demonstrate progress or lack of progress.

Follow Through

The tentative treatment plan should be reviewed in the next clinical supervision meeting to obtain input from staff and supervisors. Suggested changes to the plan may occur at that point, and therapists can discuss these new ideas with patients during their next session.

Therapists should also prepare a therapy session checklist to help focus subsequent sessions. This should be updated regularly, because treatment planning is a process of constant reevaluation, assessment, and change, based on objective indices of progress. Patients and therapists together should review, discuss, and assess the treatment plan frequently as goals are achieved or interventions fail, or as new information becomes available. These changes should also be reviewed at the regular staff supervision meetings.

Drug Avoidance Skills

In order to stop abusing cocaine, patients need to learn which people, places, and things stimulate the desire for cocaine and how to either avoid or cope with them. CRA + Vouchers teaches patients three interrelated ways to accomplish this:

- Functional analysis
- Self-management planning
- Drug refusal skills

Functional Analysis

All patients are trained in functional analysis in the early stages of treatment. Its purpose is to help them understand their drug use so they can effectively problemsolve for ways to reduce the probability of cocaine use. The approach described here is based on the work of Miller and Munoz (1982) and McCrady (1985). Functional analysis is used throughout treatment as needed. For example, if cocaine use occurs, therapists should encourage patients to analyze these events to determine how to avoid using in similar situations in the future.

Therapists should instruct patients on the concepts and procedures concerning functional analysis.

> *"We are going to focus on what is called a functional analysis of your cocaine habit. It is the first step in developing control over out-of-control behavior. Your cocaine use is triggered by certain events, situations, and feelings, and maintained by short- and long-term con sequences. Therefore, it is important that you begin by analyzing your pattern of cocaine use. Once you have learned to analyze your use, you will know how to rearrange your environment - the triggers and consequences - and how to engage in positive alternatives to cocaine or other drug use so that you can achieve total abstinence from cocaine. When you have completed this process, you will have taken a large step toward beating your cocaine problem."*
>
> *"There are four important points to keep in mind as you learn how to do a functional analysis of your cocaine use."*

- Other people with drug problems like yours have been able to learn ways to stop using cocaine.
- It is important to begin thinking of your cocaine use as something that you have learned to do. Understanding exactly how your co caine problem got started is not always necessary for learning how to stop using. Blaming other persons or events for the problem also does not help. What is important is that you begin to view your co caine abuse as a problem that you can do something about. In other words, you are responsible for your own behavior.
- The goal of this treatment program is to help you learn how to stop using cocaine and how to live a drug-free lifestyle. You will get the most benefit from our program if we can help you stop your cocaine use early so we can focus on helping you make other lifestyle changes that will promote long-term abstinence from cocaine.
- However, if you use cocaine during treatment, it is important that you do not view it as a failure. It is common for persons trying to stop their cocaine use to have slips. We will use these instances to help you understand more about your cocaine use so you can more effectively learn to stop using completely. In other words, you want to figure out what happened in that situation and how you can pre vent it from happening again in similar situations.
- It will be important for you to work on these new skills between sessions. Learning and practicing new skills and behaviors is neces sary; talking about making changes is not enough to deal effectively with such a difficult problem as cocaine dependence."

Components of Functional Analysis

After briefly describing and providing a rationale for using functional analysis, therapists should begin to teach patients about the specific components of functional analysis. Such discussions can proceed as follows.

> *"A functional analysis allows you to identify the immediate causes of your cocaine use. You have probably noticed that in certain situa tions you use cocaine, while in other situations you do not. The situ ation around us can powerfully control cocaine use, particularly if we are unaware of its influence. Some of the situations that can influ ence cocaine use are -*

- *The people you are with.*
- *The place you happen to be.*
- *The hour or the day.*
- *How much money you have.*
- *How much alcohol you have consumed.*

- *What you are doing besides using cocaine.*
- *How you are feeling.*

"The first step in understanding your cocaine use is to identify the types of situations in which you are likely to use cocaine. Your first assignment will help you identify these risky situations and what about them makes you want to use cocaine. These are called triggers.

"You will also need to identify the consequences of your use. There are two kinds of consequences: the immediate and often positive con sequences, such as getting high or having fun; and the delayed, often negative consequences, such as blowing all your money and being unable to pay a bill or having an unwanted sexual encounter.

"As you identify triggers and consequences, you will discover that there are certain patterns to your use. These patterns will become important targets for intervention."

Therapists should then go over the four components of the functional analysis: triggers, behavior, and positive and negative consequences.

Triggers

A trigger is an event that occurs before a person uses cocaine and increases the likelihood of using. Triggers can be -

- Particular individuals.
- Environmental settings.
- A certain feeling.
- A combination of these.

"Triggers can be quite obvious or they can be difficult to identify. They should not be thought of as things that make you use cocaine, but as things that increase the chance that you will use. Many times, a trigger will lead to other responses, like thoughts about using and the potential consequences of using, such as 'cocaine will make me feel better' or 'doing some cocaine will be lots of fun' or 'cocaine will help me forget that.'"

Almost anything can be a trigger.

- Being out at bars
- Your job
- An argument with a friend or family member
- Withdrawal symptoms
- Being at a certain friend's house
- Peer pressure to use
- Being home alone

- Parties
- Saturday night

These can lead to a variety of thoughts or feelings that encourage cocaine use.

Thoughts

- I can't deal with this.
- I need to get away.
- I need to forget.
- Using would be a blast.

Feelings

- Anxiety
- Depression
- Anger
- Frustration
- Happiness
- Loneliness
- Elation

Behavior

Cocaine use is one of several behaviors that could occur after a trigger. The patients' job is to learn new behaviors so they can either avoid the trigger or refuse to turn to drugs.

Positive Consequences

The positive, reinforcing consequences of cocaine use are usually experienced soon after taking the drug. Some typical positive consequences reported by users are -

- Forgetting bad negative events or feelings.
- Becoming more energetic.
- Getting rid of depressed feelings.
- Feeling less pain.
- Feeling good.
- An enhanced sexual experience.

Because cocaine use results in many of these short-term, positive consequences, it is hard to stop.

Negative Consequences

The negative consequences of cocaine use are usually experienced some time after using. These are the effects that interfere with life goals and are usually detrimental to relationships, work, finances, health, mood, and self-esteem. They are probably part of the problem that brought the patient into treatment. However, these delayed, negative consequences often occur so much later that they have little influence on future cocaine use.

Conduct a Functional Analysis

Next, therapists should instruct patients in how to do a functional analysis.

> *"The first step in doing a functional analysis of your cocaine use is to identify situations that function as triggers. We have created a form to help you get started."*

Give the patient the Discovering Triggers form **(**exhibit 13**)**. Therapists should work with patients to complete this form.

Next, give the patients a Functional Analysis form **(exhibit 14)** and go over each component of the diagram. The following steps can be used to guide this training.

> *"An easy way to identify and see your cocaine-use pattern is to use these Functional Analysis diagrams. Think of the last time you used cocaine. Write down your cocaine use in the box marked Behavior on your Functional Analysis form."*
>
> *"Next, try to remember what you were doing just before you started using cocaine. Can you remember who you were with, where you were, what you were doing, or what time of day it was? Write these in the Trigger box on your chart."*
>
> *"Before using cocaine the last time, what were you thinking and feel ing? Were you saying anything to yourself? Write whatever thoughts and feelings you remember in the box called Thoughts and Feel ings."*

"Now I would like you to list your responses to each of these questions:

- *What happened after you used?*
- *What were the effects of using cocaine?*
- *Did your mood change?*
- *Did you feel high?*
- *Did you act differently?*
- *What were your thoughts and feelings?*

Exhibit 13: Discovering Triggers of Your Cocaine Use

Patient:_____Date: _____

1.List the *places* where you are most likely to use cocaine:

2.List the *people* with whom you are most likely to use cocaine:

3.List and *times* or *days* when you are more likely to use cocaine:

4.List any *activities* that make it more likely that you will use cocaine:

5.Do you think that you use cocaine when you are feeling certain ways? Read through the following list and mark the ones that are relevant to you. For those you have marked, list specific examples from your own experience.

a.at the end of (or during) a tense day h.

b.when faced with something you fear or are anxious about

c.when you've failed to accomplish something you'd planned

d.when you feel you have been taken advan tage of

e.when you are bored

f.when you are in a social situation

g.when you feel bad about yourself

h.when you are depressed

i.when you want to feel energized or high

j.when you are faced with a tough problem

k.when you want to be friendly

l.when you wish your personality was different

m.others not listed here

6.List the places where you are *unlikely* to use cocaine:

7.List the people with whom you are *unlikely* to use cocaine:

8.List the times or days when you are *unlikely* to use cocaine:

9.List the activities you engage in when you are *unlikely* to use cocaine:

Source: Adapted from Miller and Munoz 1982.

EXHIBIT 14.- Functional Analysis - Cocaine Behavior Form

Triger	Thoughts and Fellings	Behavior	Consequences	
			Positive	Negative

EXHIBIT 14.- Functional Analysis - Cocaine Behavior Form (example)

			Consequences	
Triger	**Thoughts and Fellings**	**Behavior**	**Positive**	**Negative**
Bob comes over to apartment	Looks like good stuff. Could really get high. I deserve a break	Do 1/2 gram, then another gram.	Got really high. Bob and I had a blast. Didn't have to deal with wife.	Blew $50. Late to work next day. Wife won't talk to me.
After work, guys say, "Let's go to the bar."	I know I should go home. I'm tired and know that I'll do some coke and that will help.	Go to bar. Drink a few beers. Shoot 1/2 gram.	Had a blast. Reenergized Good high.	Wife was mad. Blew $30. Arm is sore.
Saturday night.	Time to party. Feel like getting really high. Staying home will be boring.	Go over to Tom's apartment. Get a few 6-packs. Buy an eight-ball. High till 3 a.m.	Good coke, but really high. Laughed a lot.	Blew $120. Arm sore. Missed kid's game in the a.m. Wife mad.

"Now make a list of the effects of your cocaine use over time since you began using cocaine. How has it affected your relationships, friendships, work/school, health, self-esteem, and so forth?"

"You will find that the lists you just made include some things that make you feel good and some that make you feel bad. Write down the good things in the Positive Consequences box and the bad things in the Negative Consequences box."

"You will probably notice that most of the positive consequences are events or feelings that occur with cocaine use or soon after, while the negative consequences occur some time after cocaine use, probably a long time after. This is why cocaine use becomes such a powerful habit that it is difficult to break."

"Congratulations, you have just functionally analyzed your cocaine use in that situation."

Therapists should now help patients complete one or two more functional analyses during the session. Patients should also be encouraged to complete additional analyses for the next session, using the Triggers form to identify other cocaine-use situations. Both the Triggers and Functional Analysis forms can be completed as homework if the session time expires. However, if the forms are not completed for the next session, be sure they are completed during that session.

Self-Management Planning

Therapists and patients next turn to developing self-management plans for the various triggers identified in the functional analysis. Such plans will be developed throughout treatment whenever initial plans fail or new triggers are found. Therapists start by praising the patients for doing a thorough job on the functional analysis task and then introduce the next step: learning specific ways to deal with cocaine craving.

Rationale

Therapists can paraphrase the following to explain self-management planning.

"Now that you have identified the triggers and consequences related to your cocaine use, we are going to work on developing strategies for dealing with the triggers. To do so, I will teach you a strategy called self-management planning. This training involves learning how to avoid the triggers or to replace them with other things that are less risky. In addition, you will learn how to rearrange your environment to reduce the likelihood of using cocaine."

Initiate Training

Before initiating self-management training, therapists should review with patients their functional analysis forms. This review should include the following.

- An explanation that external environmental events can often set off drug use.
- Categorization of triggers into places, people, time of day, activities, feeling, and so forth. Give examples and relate them back to the func tional analysis (after work, weekends, watching television, others using, anticipation of sexual experience).

Therapists should then explain that there are three basic ways of handling these triggers to reduce the risk of cocaine use.

> *"One way is to avoid the trigger; for example, take a route home that is different from where you obtained cocaine in the past; avoid going by your dealer's house; don't go into bars; and avoid certain people. To do this successfully, you will have to engage in new or different activities."*
>
> *"The second way to deal with triggers is to rearrange your environ ment. For example, don't keep cocaine or paraphernalia in the house, and don't carry money with you if you know you will be walking or driving past places where you might be tempted to buy cocaine."*
>
> *"The third way of dealing with triggers is to develop some new cop ing method or plan that will help you not use when you are in a particular situation. For example, you experience a trigger such as extra cash in your pocket. Instead of using the money for drugs, en gage in some incompatible behavior. For example, you might call your spouse or do some activity that you enjoy, like working out at a gym or shopping for something special for you or your family."*

Make the Plan

Using the patients' Functional Analysis forms, therapists can ask them to pick out a few triggers and then discuss how they might handle those triggers to reduce the chances of using cocaine.

Using the Self-Management Planning Sheet as a guide **(exhibit 15)**, therapists can lead patients through the following steps.

- Choose a trigger. Start with one that often leads to cocaine use. If possible, choose a trigger that is likely to come up in the near future, before the next session, so the patient will be prepared to deal with it.
- Brainstorm and write down a list of potential strategies for either avoiding the trigger, rearranging the environment so the trigger does not occur, or identifying a new coping method for dealing with the trigger when it does occur. Any and all possibilities should be writ ten down. Therapists should encourage patients

Exhibit 15: Functional Analysis - Cocaine Behavior Form			
Trigger	**Plans**	**+/- Consequences**	**Difficulty (1-10)**
1.	a.		
	b.		
	c.		
	d.		
	e.		

to be open to any ideas no matter how difficult, easy, simple, complex, or crazy they sound. If needed, therapists should model brainstorming by suggesting many possibilities, some outrageous, some impossible to do, and some simple.

- Together, therapists and patients should consider the overall effects or consequences of each proposed strategy for dealing with the trigger and write these down.
- Therapists should then ask patients how hard they think it will be to carry out each strategy using a scale of 1 (not very difficult) to 10 (ex tremely difficult).
- After considering all the potential strategies, their consequences, and their perceived difficulties, one strategy should be selected.
- Therapists then ask patients to rehearse the chosen strategy. For example, if the plan is to avoid passing by an old friend's home, have the patient plot a different way home. If the goal is to arrange to be at a safe person's house during a high-risk time, have the patient role-play calling this per son to arrange to be there. Better yet, have the patient actually call that person during the session to arrange this get-together.
- Plans for handling two or three triggers should be completed in the ses sion until therapists feel that the patients understand how to do self-man agement planning.
- Set a goal for patients to complete additional Self-Management Plan ning Sheets during the week. If they are not completed by the next session,they should be completed during the session.
- Set a goal for patients to carry out at least one of the plans before the next session. Discuss what situations might be coming up this week and re view the plan again before patients leave the session.

Drug Refusal Training

Drug refusal training is included in most patients' treatment plans. As many as one-third of substance abusers relapse as a direct result of social pressure from friends to use. Most cocaine abusers who are trying to quit continue to have some contact, either planned or inadvertent, with friends or acquaintances who are still using. Turning down cocaine or opportunities to go places where co-caine is available will be much more difficult than most patients anticipate. The ability to refuse cocaine or other drugs when offered is a special case of assertiveness.(The structure of this training is adapted from McCrady 1986 and Sisson and Azrin 1989.)

Rationale

When initiating drug-refusal training, therapists begin by explaining why this will be important to the patients.

> *"Drug refusal training can be very important in helping you achieve a substantial period of abstinence and for maintaining that absti nence. We are going to practice ways to refuse cocaine or to refuse to go to places where cocaine is available. The ability to effectively say no in these situations will help you feel in control when faced with situations that are tempting and to which you may previously have said yes automatically."*

> *"Our experience is that patients usually underestimate the difficul ties encountered when trying to refuse or avoid cocaine. You may feel that you will have no problem saying no, or that no one will ask you if they know you are trying to quit. However, previous patients have found that, if they do not prepare themselves to deal with these situations, good intentions do not always lead to effective refusal. What we and our patients have found to be helpful is to plan and repeatedly practice using specific refusal skills for handling high-risk situations that may arise."*

> *"We have developed a training protocol that is designed to teach or remind you of some effective ways to say no when opportunities arise. An important component of this training is for you to be creative in anticipating many of the situations that may come up in the followi ng months. We have developed some examples that we feel are typi cal of what many cocaine abusers face, but each person has a unique set of circumstances. This training will benefit you most if you in clude situations relevant to your life so that we can rehearse how to handle them."*

Refusing Cocaine and Other Drugs

Therapists then initiate a discussion and provide information concerning how patients can learn to effectively refuse cocaine. Some important concepts and instructions are presented as follows.

> *"Remember that those persons who offer you cocaine or alcohol are not thinking of your best interests. They may be your friends, but once you have decided to quit, it is important for you to consider anyone who asks you to use cocaine or go party as a pusher. They must be discouraged - politely, if possible, but firmly."*

> *"Saying no is the first and most important part of your refusal re sponse. There are different ways of saying no that are appropriate in different situations. Different people say no in different ways. It is important to feel comfortable, which means that you have to develop your own style. When working to develop your style, it is important to keep a few goals in mind.*

- *Your primary goal is to refuse or turn down cocaine.*

- *Your secondary goals might be to -*
- *Reinforce your commitment to not use.*
- *Feel good about yourself for doing it."*

Components of Effective Refusal

"When creating your own refusal style, a few basic components of your refusal responses will increase the likelihood that they will be effective.

- *No should be the first thing you say.*
- *Tell the person offering you drugs or asking you to go out not to ask you now or in the future if you want to do cocaine. Saying things like 'maybe later,' 'I have to get home,' or 'I'm on medication' just make it likely that they will ask again.*

  -Body language is important.

  -Making good eye contact is important; look directly at the person when you answer.
- *Your expression and tone should clearly indicate that you are seri ous.*
- *Offer an alternative if you want to do something else with that per son. Make sure that it is incompatible with cocaine use (taking your children for a walk or to the park, going to work out).*
- *Change the subject to a new topic of conversation.*

Practice Refusal Skills

Next, therapists help patients begin to develop personal refusal styles. Basic examples of saying no are provided.

- No, thank you.
- No, thank you, but I'll have some coffee or something to eat.
- No, I'm not using anymore; it is causing me too many problems.
- No, I've got a cocaine problem, so I'm not using anymore.

Therapists then help patients construct at least three typical scenes in which patients have had or may have difficulty refusing cocaine. Examples of such situations are friends stopping by with cocaine, friends calling on the telephone, running into friends while shopping, special occasions, parties, or leaving work. The situations that they choose should be very specific. That is, they should include specific people, specific times of day, and so forth.

Exhibit 16: Components of Effective Refusal

- *No* should be the first thing you say.
- Tell the person *not to ask you now or in the future* if you want to do cocaine.
- Use appropriate body language:
- Make good eye contact; look directly at the person when you answer.
- Your expression and tone should clearly indicate that you are serious
- Offer an alternative (if you want to do something else with that person) that is incompatible with cocaine use.
- Change the subject.

Therapists and patients then role-play two or three of these situations. Before starting, therapists remind patients of the components of effective refusal and the goals for the situation. A list of these components is provided for the patient to refer to before and during refusal practice attempts (exhibit 16).

For each situation, therapists first have the patients function as themselves, with the therapist acting as the person offering cocaine. After each trial, constructive feedback is given. Therapists continuously refer to the components and goals of effective refusal when giving feedback. Examples or alternatives are given as needed. Problems with some of the patients' tactics are pointed out if they seem ineffective. Following the feedback, the role-play is repeated. When patients experience a lot of trouble, therapists reverse roles with them and model an effective response.

Second, therapists have patients act as the person offering drugs, and the therapists act as the patient. The same procedures are followed. Therapists initiate a discussion of how it feels to be in the different roles: What is hard? What is easy? What feels comfortable? What does not?

Patients may have difficulty with some components. Teaching the components one or two at a time may be a useful method for helping them develop effective refusal skills. Therapists should model the components that they have difficulty with by using role reversal.

Homework

Therapists should remind patients that the most important thing in developing effective refusal skills is practice. Weekly practice goals are set. For example, two high-risk situations can be identified, and patients can practice these scenes each day between sessions. If the patients have partners to practice with, this can be scheduled either during or outside of the session. If patients do not have anyone to practice with, they can either practice aloud in front of a mirror or write down a refusal scenario with responses and bring it to the next session for practice.

In addition, therapists should ask patients to identify situations during the next week in which they may be confronted by a pusher. These situations should be rehearsed in session, and therapists should contract with patients to practice this refusal scene daily and to refuse in that real-life situation.

Lifestyle Change Components

An essential part of the treatment for cocaine abuse involves helping patients change their lifestyles. To accomplish this, they may need new skills, new information, or steady prodding. The therapists' task is to identify, with patients and based on the initial assessments, the types and areas of assistance required. Then patients acquire the skills needed to mold themselves into the kinds of people they want to become. This chapter outlines a number of skills-training components in the areas most commonly addressed by cocaine abusers in treatment:

- Time management
- Social and recreational activities
- Problemsolving
- Vocational satisfaction
- Social skills
- HIV infection prevention

These components are provided as needed. Other types of skills training (e.g., anger management) should also be available.

Time Management

The substantial lifestyle changes needed to achieve and maintain abstinence from cocaine require that patients make productive use of their time. They must learn to plan and schedule events and activities so they have little idle, high-risk time available. Many patients do not keep regular schedules, and some express resentment at the suggestion that this might be helpful. However, planning and scheduling activities increase the likelihood that patients will follow through with treatment goals and activities. Thus, time-management training is provided to most patients.

Therapists can introduce the idea of time management in the following manner.

"This part of your treatment involves learning to plan, schedule, and prioritize the events and activities in your life. Solving your cocaine problem requires making many substantial changes; it is important to develop efficient ways to do this. Some patients say they don't like to plan or they like to be spontaneous, but if they don't find a way to schedule and organize their lives, they eventually become over whelmed and don't achieve their goals. It is important to spend time on this issue in treatment."

Develop Time-Management Skills

The importance of writing down and scheduling appointments and activities should be reviewed at each session. Therapists should inform patients that this practice can increase followthrough with plans and goals, reduce stress, help avoid missed appointments, increase awareness of accomplishments, and help organize and prioritize plans.

The first step is to make sure that patients have the appointment books provided during the first session. Since patients often lose these books, an effective alternative is to give them photocopies on a week-by-week basis. The next step is to show patients how to effectively use the appointment book. Therapists should stress the importance of establishing a regular pattern of using the book. Suggest that patients get their books out each morning at a regular time.

"Planning is usually done best first thing in the morning or at the end of the day. There are many advantages to planning in the morni ng when you are fresh. Having just thought about what you have to do, you can move easily to getting it done. With the day's priorities clearly in mind, you will be less likely to be sidetracked as you go along. Also, you can review any scheduled activities for the day."

Patients should make a list of what they would like to accomplish that day or before the next therapy session. Therapists should then point out how all the items on a list are not of equal importance and introduce the ABC system of prioritizing (Lakein 1973). In this system, therapists ask patients to write a capital "A" beside those items on the list that have a high value, a "B" for those with medium value, and a "C" for those with low value. Items marked A should be those that yield the most value.

"You will get the most out of your time by doing the A's first and saving the B's and C's for later. By taking account of the time of day and the urgency of the items, you can even break them down further so that A items become A-1, A-2, A-3, and so on. How detailed you get depends on you and the number of activities on your list."

After the prioritizing is complete, therapists should help patients make realistic plans and schedules and enter them in the appointment book.

The priority given to each item guides where and when it is written. At first, patients may try to place more into their schedules than they can possibly accomplish. Also, some make poor choices about which activities to schedule when. Here, therapists need to guide and teach patients about efficient, realistic time-management planning.

Patients should be encouraged to make a separate "To Do" list each day. As they complete each activity, they should cross it off the list. Then, at the end of the day, they will be able to check on how many items have been completed. It is important that this list be on a single piece of paper rather than jotting down items on miscellaneous scraps of paper. Patients should be encouraged to keep the list in their appointment books so it is accessible and useful.

Apply Time Management

Therapists should ask patients to practice these time-management procedures (i.e., daily scheduling and keeping daily lists) during the coming week. Have them choose a specific time of day to do this. Patients should also be instructed to bring their appointment books and daily lists to *each* session.

Therapists should encourage daily and continuous use of these procedures throughout treatment and help problemsolve any difficulties that patients may have in completing the exercises. Emphasis is placed on making this a daily routine for the next few months and perhaps for many years to come.

If patients do not comply with these exercises between sessions, therapists should always try to have them use the appointment book and make daily lists while in session. This repeated in-session exercise may help reinforce between-session compliance.

Social/Recreational Counseling

This component of CRA + Vouchers focuses on developing interest and participation in recreational and social activities that are pleasurable for the patient and do not involve cocaine or other drug use. The goal is to increase participation in social activities that may serve as alternatives to cocaine use.

Rationale

Therapists should provide a rationale for working on lifestyle changes in social and recreational areas.

> "Many times, when cocaine or other drugs become a regular part of someone's life, they either stop doing many of the nondrug activities they used to enjoy, or they never start or develop any regular recre ational activities. For example, many drug abusers, like anyone else, used to play sports, work out or exercise, go on hikes, go out to the

movies, visit relatives, and so forth. But as drug use increases, it gradually replaces these other activities."

"Social and recreational activities are important in most people's lives. They provide -

- *A source of enjoyment that can be looked forward to after a stressful day at work or taking care of the kids.*
- *A way to decrease boredom when you have free time.*
- *A way to feel physically healthy.*
- *An outlet for developing a skill that makes you feel good about your self.*
- *A chance to be with people you like to develop friendships."*

"These activities can play a very important part in becoming and staying drug free. When you give up using drugs, you have to do something else during the times you were using. If the things you do are not satisfying or enjoyable, or you don't do anything but sit around and feel lonely or bored, you are more likely to use drugs."

"Developing satisfying, regular social and recreational activities is difficult for many people who are trying to quit cocaine. Sometimes it is hard to -

- *Find anyone to do things with who is not a drug user.*
- *Think of things you would like to do that are affordable.*
- *Fit activities into your schedule because of work or family responsi bilities.*
- *Become motivated to start something new."*

"This is why we have a specific treatment component to assist pa tients in developing a regular schedule of social and recreational activities."

List Activities and People

The first step in social/recreational counseling is to develop a list of potentially reinforcing activities that patients are interested in pursuing. Therapists should gather possibilities from patients by asking about -

- Current activities.
- Activities enjoyed in the past.
- Things patients have always wanted to do, but have never done.

Therapists could also use the Leisure Interests Checklist (Rosenthal and Rosenthal 1985) to assess the patients' interest in various activities. This checklist can be administered either in-session or as an assignment between sessions. As with any assignment, if the checklist is not

completed as scheduled, it should be completed during the next session.

Once possible activities are identified, therapists and patients should attempt to categorize activities by amount of interest, cost, others' involvement, time commitment, likelihood of engaging in the activity, and whether it is physical or sedentary.

An important goal for most patients is to increase time spent with nondrug-using persons and discontinue interaction with drug abusers. Thus, the next step is to create a list of persons who might participate in activities with the patient. This can be very difficult, because patients will often report that they don't know anyone who is not a drug user or alcoholic; this is rarely true. With gentle prompting by therapists about extended family and old acquaintances, patients can usually name at least one safe person to target as a contact.

If patients are unable to identify anyone, therapists should move on and come back to this issue later. Finding safe people has high priority, since establishing a social network of nonusing friends or family members can play a substantial role in the achievement and maintenance of cocaine abstinence. As a last resort, clinic staff may accompany patients who are trying out a new activity as a way to establish interest and increase the probability that they will ask a nondrug-using friend to participate in the future.

Set Goals and Assess Progress

Therapists and patients should agree upon goals for directly participating in a particular activity, taking the necessary steps toward participation, or increasing the time spent with nondrug-using persons. Behavioral techniques for effectively setting goals and shaping behavior can be applied here. These goals should then be incorporated into the treatment plan and systematically worked on throughout the course of treatment. Progress should be assessed in each session and any problems or changes in goals dealt with at that time.

Facilitate Change

If patients express fears about doing certain activities or meeting people, therapists should assess the extent of the problem and offer to help with problemsolving, social skills training, behavioral rehearsal, or another appropriate procedure. If applicable, therapists should encourage the use of vouchers from the incentive program to pay for these activities. Also, if significant others are participating in treatment, they can help involve the patients in new activities.

Therapists can also help in this area by providing patients with listings of local activities, recreational facilities, continuing education classes, and other community resources and activities. In essence, the therapist

or another staff member can function as a source of information about available social/recreational opportunities in the community. This means therapists will need to review local newspapers, bulletin boards, and radio advertisements and make contact with community agencies prior to sessions.

For patients who seem unable to sample social activities, therapists might use scheduled sessions to initiate such behavior. For example, therapists could take patients bowling, shopping for crafts, to the YMCA, to play tennis or basketball, or to a museum.

Problemsolving

Achieving cocaine abstinence and making substantial lifestyle changes involve finding solutions for many problems. Some patients may have so many problems that even minor problems seem overwhelming. For example, a straightforward goal like going to a job service center to meet a therapist and signing up for assistance may require solving a number of problems. The patient may not have readily available transportation, childcare may be needed, or the only available appointments may conflict with other important activities.

For many patients, their cocaine abuse has resulted in either avoidance of such problems or making impulsive decisions that are not in their best interest. Such poor problemsolving behavior usually results in negative consequences that increase the severity of existing problems or create additional problems. Thus, an important component of CRA + Vouchers is skills training in effective problemsolving. The method is similar to that used by Monti et al. (1989) in the treatment of alcohol dependence. The goal of this training is to teach patients to identify, analyze, and find solutions for the many problems they will face in their efforts to stop cocaine use and make lifestyle changes.

Rationale

Therapists should provide a rationale for this component.

> *"Persons trying to recover from cocaine problems often find them selves confronted by difficult situations. These situations become prob lematic if you do not have an effective response for them. Cocaine abusers are likely to encounter several types of problems.*

- *Finding themselves in situations where they have used cocaine and other drugs in the past*
- *Having to deal with social pressures*
- *Craving drugs or relapsing*

"Some common problems are encountered in making positive lifestyle changes.

- *Having difficulty finding the time to participate in social activities or hobbies*
- *Lack of transportation*
- *Problems with childcare*
- *Job-related issues*
- *Family pressures*
- *Legal problems*

"Effective problemsolving requires that you recognize the fact that you face a problem situation and resist the temptation either to re spond to your first impulse or to do nothing. If you don't find good s olutions, your problems can build up over time, and the pressure may eventually get to you and trigger cocaine use. We have a pro gram for helping you become a better problem solver. To become good at this skill usually takes some time and a lot of practice."

Steps for Problemsolving

At this point, therapists should introduce the basic steps for prob-lemsolving.

- Recognize the problem
- Identify the problem
- Brainstorm
- Select the approach
- Evaluate its effectiveness

Recognize the Problem

Therapists should review several questions that patients can ask themselves to become more aware of problem situations. The following are some sources of clues that a problem exists.

- Your body (e.g., tension, craving)
- Your thoughts and feelings (e.g., worry, depression, loneliness,
- irritability)
- Your behavior (poor work performance, not meeting responsibilities in your family, with friends)
- Your reactions to other people (e.g., irritable, lack of interest, isola tion)
- Others' reactions to you (e.g., avoidance, complaining)

Identify the Problem

Patients need to learn to clearly label or identify a problem once they realize that something is wrong. They should collect as much information and as many facts as possible to help clarify the problem. For example, if patients are upset about their current job and are considering quitting, the therapist could work with them to clearly identify what is problematic about the job. Questions such as the following could be asked.

> *"Do you get along with your coworkers?"*
>
> *"How is your relationship with your supervisor?"*
>
> *"Have you received any negative feedback or evaluations?"*
>
> *"Is the pay high enough? Have you asked for a raise?"*

More and more detailed questions should be posed as therapists focus on the problem.

Brainstorm

It is important to develop a number of solutions to a given problem, because the first one that comes to mind may not be the best. When brainstorming, list all possible solutions but do not evaluate them yet. Patients should be encouraged to list ridiculous as well as serious solutions, the most difficult as well as the easiest solutions, and the "worst" solutions as well as the "best" solutions.

Select Approach

The next step is to select the most promising approach. Therapists should help patients evaluate each potential solution and identify the most probable outcomes for each possible solution. Be sure to consider both positive and negative outcomes and both long- and short-term consequences. Also evaluate the difficulty of implementing each solution. The decision on which solution to try first is made after considering both the ease of implementing the solution and the potential for a positive outcome.

Evaluate Effectiveness

Once a solution is chosen, therapists should discuss the next step, evaluating its effectiveness. Here, emphasis is placed on the need to evaluate and try again if the solution is not effective. Also, it is important that therapists help patients determine how they will know if it is effective. Determining this ahead of time helps patients be more realistic and perhaps optimistic about finding effective solutions to problems.

Practice

Therapists next provide several problemsolving

Exhibit 17: Problemsolving Worksheet

Procedure

Gather information: Recognize that a problem exists. Is there a problem? You get clues from your body, thoughts, feelings, behavior, reactions to other people, and the ways that other people react to you. Think about the problem situation. Who is involved? When does it happen? Exactly what takes place? What effect does this have on you?

Define the problem: Describe the problem as accurately as you can. What goal would you like to achieve? Be as specific as possible. Break it down into manageable parts.

Brainstorm for alternatives: List all the things that a person in your situation could possibly do. Consider various approaches to solving the problem. Even list alternatives that seem impractical. Try taking a different point of view, try to think of solutions that worked before, and ask other people what worked for them in similar situations.

Consider the consequences: Look at each of your alternatives in turn. What things could you reasonably expect to result from taking each action? What positive consequences? What negative consequences are long-term? Which are short-term? Which do you think you could actually do?

Make a decision: Which alternative is the most likely to achieve your goal? Select the one likely to solve the problem with the least hassle.

Do it! The best plan in the world is useless if it isn't put into action. Try it out.

Evaluate its effectiveness: Which parts worked best? Reward yourself for them. Would you do anything differently next time? After you have given the approach a fair trial, does it seem to be working out? If not, considerwhat you can do to beef up the plan or give it up and try one of the other possible approaches. Remember that when you've done your best, you have done all you can do.

continued

Exhibit 17: Problemsolving Worksheet

Practice Exercise

Choose a problem that may arise in the near future. Describe it as accurately as you can. Brainstorm possible solutions. Evaluate the potential outcomes. Prioritize solutions.

Identify the problem situation:

_____

_____

_____

_____

Brainstorm a list of possible solutions:	Pros:	Cons:
_____	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____

Vocational Counseling

Satisfying, gainful employment or career activities can play an important role in achieving and maintaining abstinence from cocaine and other drugs of abuse. Therefore, vocational counseling is an important component of CRA + Vouchers. The procedures are based on those outlined in Azrin and Besalel's "Job Club Counselor's Manual" (1980). We have adapted it for use in individual rather than group settings. Counselors providing this vocational component will benefit from familiarizing themselves with the Job Club manual.

A job counselor is available to work with patients throughout the week, and therapists use Job Club procedures in individual counseling sessions when appropriate. This counseling focuses on helping unemployed patients locate work and on improving the employment situation of patients who consider their jobs unsatisfactory or have jobs that place them at high risk for continued drug use.

Rationale

The rationale for making positive changes in this area is straightforward. Therapists initiate a discussion about the role of a satisfying vocation in the short- and long-term maintenance of drug abstinence.

> *"In drug abuse treatment, one of the predictors of long-term success is stable, satisfying employment. This relationship between abstinence and employment satisfaction exists because -*

- *When you work at a job you like, you are unlikely to use cocaine while working.*
- *You are less likely to jeopardize that job by coming in late or missing work because of late-night partying.*
- *The job makes you take pride in and feel good about yourself.*
- *The job provides you with the financial means to access other*
- *positive things, such as social and recreational activities, and desir able housing and transportation.*
- *Sometimes the job also provides a source of social support, friend ship, and social activities that are unrelated to drug use."*

Set Goals

The primary goal of vocational counseling is to assist patients in finding satisfying employment or in taking steps toward the development of a meaningful career. Similar to other components of CRA + Vouchers, therapists first conduct a thorough assessment and then collaborate with patients to set behavior-change goals. For example, many patients have difficulty initiating job-seeking behavior. Thus, in the spirit of the Community Reinforcement Approach, therapists can take patients to fill out applications or provide job leads for those patients who do not take the initiative. The goals of vocational counseling vary depending

on the individual patient's situation. Below are examples of goals that are typically set in the vocational counseling component.

For the unemployed patient:

- Make eight job contacts per week.
- Develop a resume
- Send out two resumes with a cover letter each day.
- Go to the job service twice a week.
- Enroll in a job training program.
- Enroll in a vocational exploration program.
- Take a job-skills-related class.
- Collect and consider information on educational possibilities.

For the patient who works "too many" hours or has an irregular schedule:

- Keep work to 35 - 50 hours each week.
- Establish a more regular schedule.
- Explore alternative work schedules.

For the patient working in a "high risk for drug use" environment or the dissatisfied employee:

- Consider a job change.
- Submit applications for alternative employment while continuing to work.
- Modify the work environment to reduce risk of drug use or improve working conditions.
- Enroll in a career exploration class.
- Enroll in job-skill or alternative career-related educational classes.

By the end of the first session of vocational counseling, therapists and patients should have set a long-term goal (e.g., full-time employment as a secretary) and specific, short-term attainable goals (e.g., five job contacts per week, employment with a temporary agency, enrollment in a computer skills class). These goals should be monitored and changed, as needed, until patients achieve their long-term goal. In this respect, vocational counseling is typically an ongoing component throughout treatment.

Treatment Components

The following vocational counseling services are provided to patients by either the Job Club counselor or the therapist.

1. The therapist encourages patients to *treat the job search as a full-time job*. The suggested timeframe for this is to spend half of each workday looking for job leads and setting up interviews and the other half going to interviews. Patients are to continue with this schedule each day until they find a job.

2. The therapist advises patients to *systematically contact friends, rela tives, and acquaintances for job leads.*

3. The therapist provides *standard scripts and forms* to follow when making contacts with potential employers, for writing letters, for making telephone calls, and for keeping records.

4. The therapist provides the *supplies and services* necessary for a job search. Patients should have access to a work area, telephone, com puter, photocopier, postage, and newspapers.

5. The therapist encourages patients to *seek job interviews and applic ations for jobs that are not advertised.* For example, the patient could call all the manufacturing plants, all the car dealerships, or all the haircutting establishments in the yellow pages.

6. Patients are encouraged and taught to *use the telephone as the pri mary means for obtaining job leads.* This is a more efficient method than letters or visits.

7. The *yellow pages* section of the telephone book is used to make lists of potential employers.

8. The therapist helps patients learn how to *promote strengths other than work skills* (i.e., social and personal skills). These skills can be highlighted in a resume when making job contacts as well as during interviews. In addition, the therapist helps patients identify and list marketable work-related skills that were not necessarily acquired during previous employment.

9. The therapist helps patients learn how to *make the most of unsuc cessful job contacts,* that is, learn how to ask that source for other job leads.

10. Patients learn to *recontact a potential job source following an inter view.* This can help demonstrate their interest and enthusiasm for the job to the employer. Also, after an unsuccessful contact with a very desirable job source, patients learn to call that

employer back after a period of time in search of future opportunities.

11. The therapist helps patients learn how to *arrange transportation to job sites that are difficult to get to* for whatever reason.

12. Patients are encouraged to *contact previous employers for jobs or job leads.*

13. Patients are encouraged to *get open letters of recommendation from multiple sources.* These can be used when submitting applications or when interviewing to expedite the employer's decision.

14. The therapist helps patients *build an effective resume.*

15. *The therapist provides advice and instruction on how to effectively fill out an application (e.g., emphasize personal skills).*

16. *The therapist provides training on how to effectively present yourself at interviews.*

17. *The therapist provides a list of effective behaviors that should occur during an interview. After each interview, the list is reviewed and feedback provided.*

18. *Patients who cannot find a job in a reasonable amount of time should be encouraged to place a job-wanted ad in the newspaper. This ad emphasizes personal skills and the type of work the patient is seek ing.*

19. *The therapist encourages patients to create a structured job-seeking schedule. A datebook or form is used to schedule each day's activi ties.*

20. *Patients engage in recordkeeping using such things as job lead lists, call-backs, and progress notes.*

21. *The therapist encourages patients to contact job supervisors rather than personnel staff. Sometimes the supervisor has an important role in making hiring decisions.*

22. *The therapist instructs patients in how to discuss handicaps (e.g., physical limitation, prison record) with a potential employer and how to turn them into strengths.*

23. The therapist encourages patients to consider a variety of jobs so they do not restrict themselves to the extent that they do not find employment.

24. The therapist provides continued assistance until a job is obtained.

Social-Skills Training

Social-skills training is provided to patients who report or demonstrate difficulties in -

- Meeting nondrug-using peers.
- Interacting with coworkers or roommates.
- Attending social activities because they feel uncomfortable in social settings.
- Expressing their feelings or asserting themselves in an appropriate way.

The goal is to help patients learn how to better handle interpersonal situations so they can experience more positive reinforcement and fewer negative, aversive effects from social interactions. The particular skill area to be addressed depends on the patient's needs (e.g., anger management, anxiety in social situations, initiating pleasant conversation). Effective procedures for social-skills training with alcoholics and drug abusers have been outlined by Chaney (1989) and Monti and colleagues (1989).

This chapter provides a detailed protocol for assertiveness training to illustrate the structure of a skills-training protocol. Most patients will benefit from help in this area, since studies have shown a relationship between lack of assertiveness and drug use.

Assertiveness Training

Assertiveness training is appropriate for patients who tend to be either too passive or too aggressive in social situations. Because of these tendencies, these patients are unable to effectively obtain what they want in certain situations. As cocaine abusers try to make positive lifestyle changes, their ability to effectively communicate their needs becomes important in developing alternative, nondrug reinforcements. Assertiveness training is one method for increasing positive experiences and decreasing negative experiences in social settings. Our procedures for implementing assertiveness training are based on those outlined by Alberti and Emmons (1982) and McCrady (1986).

Rationale

Therapists should tailor the rationale for assertiveness training to the needs of the patient.

> "Your functional analysis showed that at least one of your triggers is your inability to handle certain situations. Your positive consequences from cocaine use included feeling free to express yourself, more

relaxed, less depressed, and more powerful. If you can learn to deal with these unpleasant situations and to create these positive feelings without cocaine, you will have a much better chance of remaining drug free."

"Learning how to be assertive will enable you to act in your own best interest, to stand up for yourself without experiencing excessive anxiety, to express your feelings honestly and comfortably, and to exercise your personal rights without denying the rights of others."

Define Interpersonal Style

Learning and practicing assertiveness skills typically take two to four sessions. Therapists should begin by defining assertiveness for the patient: what it is, what it is not, and the results of assertiveness and its alternatives. Descriptions and consequences of passive, aggressive, and assertive behaviors should be discussed with patients. Help patients recognize which styles they tend to use, when they use them, how they affect them, and how they can act assertively in more of these situations. Point out that assertive people can also choose to be passive or aggressive if the situation requires it.

The following points about each interpersonal style should be integrated into the discussion.

- Passive behavior causes you to -
- Deny yourself or your rights.
- Avoid expressing feelings.
- Feel hurt and anxious.
- Allow others to choose for you.
- Fail to achieve your desired goals.
- Aggressive behavior causes you to -
- Accomplish goals at the expense of generating hatred and resent ment in others.
- Express feelings and promote self-enhancement, but usually hurt others in the process.
- Minimize others' worth and put them down.
- Make choices for others, and deny them their rights.
- Assertive behavior enables you to -
- Express your feelings honestly.
- Achieve your personal goals.
- Respect the feelings of others.

Exhibit 18: Being Assertive

- Clearly express your needs (what you want).
- Tell the other person why you want it.
- Balance the negative with the positive. That is, if you have to be critical or say something that implies blame, express something positive first. For example, "I know you have really tried to be supportive and understanding of my problem in the past, but lately I feet like you have been on my case constantly."
- When expressing your feelings or needs, try to use "I" statements. For example, you could say "I am angry because I feel like nobody cares about my feelings," instead of "You make me feel awful."
- Try not to express feelings or need with "you" statements. They usually cause the other person to act defensively and strike back.
- Acknowledge the other person's rights and feelings in the matter. For example, "I know it is hard for you to always check in with me first, but that would make me feel much better, less anxious, and more valued."
- Try to be as specific as possible when describing your needs and any changes that you request. For example, "I would feel much better if you would not say 'I told you so' when I make a mistake at work. If you could just tell me I made a mistake, I would be happy to fix it."
- When responding to a request, try to sound strong and definite. For example, you might say "No I do not want to do that, I have important plans that I need to attend to," rather than "I don't think so, I don't really feel much like it today."
- Speak loudly and firmly. Your message should be said with authority but not hostility. You want to convey that you mean business.
- Respond promptly. This lets the other person know that you have thought about this and are sure of yourself.
- Make good eye contact. Look at the other person when you speak and when you listen. Again, this promotes the impression that you are serious about your message.
- Your body gestures and facial expressions should be consistent with your message. For example, don't smile if you are angry.

- Improve how you feel about yourself.

In summary:

- Passive: You are hurt by not getting what you want.
- Aggressive: The other person is hurt and may seek revenge.
- Assertive: Neither person is hurt, and both get what they want.

Assertiveness Skills

Therapists should give patients the Being Assertive handout (exhibit 18) and encourage a discussion of each point.

Practice

Therapists and patients now choose two situations from the patients' Functional Analysis in which patients would benefit from being assertive. Behavior rehearsal and role-play are used to practice assertive responses in the two situations. Therapists should give feedback after each attempt and have the patients practice two or three times.

Set Goals and Assess Progress

After patients have made significant progress during rehearsal, therapists and patients collaborate in setting a between-session goal for either rehearsing assertive responses or actually attempting assertiveness in a specific situation.

At the next session, progress is reviewed. Problems are discussed, and feedback and social reinforcement are given by the therapist. Additional role-playing and rehearsal of either the same targeted situation or a new situation occur in this session. Again, appropriate between-session goals are set for practicing assertive behavior. This process of goal-setting, evaluation, and practice continues until the patients meet their goals.

HIV/AIDS Prevention

At least one or two sessions during the early stages of treatment should be devoted to HIV/AIDS education and, if warranted, counseling on the needs and risk behavior of the patients.

The following tasks should be accomplished in this component.

- Patients complete an AIDS knowledge test (pretest).
- Patients watch and then discuss a video on HIV and AIDS.
- Patients are given copies of HIV/AIDS pamphlets and condoms (if desired).
- Patients complete an AIDS knowledge test (posttest).
- Patients are given information about being tested for HIV antibod ies and hepatitis B and C.

Rationale

The rationale for HIV infection counseling can be provided to patients by the therapist as follows.

> *"We will take time during your treatment to provide education on HIV, the AIDS virus, and other diseases commonly associated with drug abuse, like hepatitis B and C. The most common way these dis eases are spread among drug users is needle sharing. Injection drug users are more likely to contract HIV or hepatitis B or C than are intranasal users or smokers of cocaine. However, even users who do not inject are at increased risk because these diseases are also spread by sexual activity. If you associate with other drug users and have intimate contact with one who injects or has had sexual contact with an injection user, you are placing yourself at risk for getting these diseases. It is important for you to have the knowledge you need so you can protect your health as well as the health of other people you love or associate with."*

AIDS Knowledge Pretest

Next, patients are given an AIDS knowledge test to complete in session. A sample test is shown in **exhibit 19**. The purpose of assessing knowledge of HIV transmission is to assure that there is no confusion about how one can contract the virus and, more importantly, to ensure that patients recognize the behaviors that place them at risk for transmitting or becoming infected with the virus.

When patients have finished the questionnaire, therapists should review each item and answer any questions the patients may raise. Therapists should ensure that ample time is given to the discussion of incorrect answers and that any misconceptions the patients have are clarified. Supervisors should ensure that therapists themselves have the correct information.

Video and Discussion

After the pretest, patients should be shown an AIDS education video. In the discussion after the video presentation, therapists should add or emphasize the following information.

- Explain that HIV infection is now growing fastest among injection drug users and their sexual partners. Although gay men were the first to become infected in this country, the virus has now spread to the entire community. Almost 25 percent of AIDS cases have involved injection drug users, their sexual partners, or babies born to these individuals. Moreover, more than half the women with AIDS in the United States are injection drug users or sexual partners of such us ers.

- Make certain patients understand that HIV infection leads to AIDS, and that AIDS is a fatal disease in which the body can no longer fight off infections and malignancies (hence the name, acquired immuno deficiency syndrome).

- Review the three ways that HIV can be transmitted: (1) through sexual contact with an infected person, (2) through blood (as in needle shar ing), and (3) from infected mothers to their babies. Explain that HIV is transmitted most efficiently through blood, and that sharing needles and other drug paraphernalia that might be bloody is an easy way for the virus to get from one person's system into another's.
- Emphasize that people who are HIV infected do not necessarily look sick and may not know they are infected. You cannot tell by looking at people whether they have the virus. People can carry the virus and not get sick for several years, but they can still infect others.
- If patients are currently injection drug users, point out that the only totally safe thing to do is to stop injecting drugs. If they continue to inject drugs, they should use new needles or clean them after each use. Explain the steps for appropriate syringe cleaning and provide them with a handout reviewing prevention tactics **(**exhibit 20**)**.
- Unprotected sexual intercourse with the exchange of body fluids (blood, vaginal fluids, semen, pre-ejaculatory fluid) is also an effi cient means of giving or receiving the virus. Sex can be made safer (if the partner's HIV status is unknown) by using latex condoms and a spermicide that contains the ingredient nonoxynol-9 with every sexual encounter, whether it is oral, vaginal, or anal.
- Point out that alcohol and other drug use contribute to risk because they can suppress the immune system, and they impair judgment in ways that can lead to increased risk taking, such as injection drug use and unsafe sex.

Pamphlets and Condoms

After viewing the video and discussing HIV infection, therapists should give patients currently available pamphlets on HIV/AIDS.

Therapists should then tell patients that condoms are given away free by the clinic and where to find them (some agencies leave them in the restrooms). If patients are hesitant about asking their partners to use them, this will need to be worked out in session. Role-playing these uncomfortable situations will be especially useful.

AIDS Knowledge Posttest

At the beginning of the session *following* the AIDS video and discussion, patients should retake an AIDS knowledge test in session to ensure that they fully understand and remember what they were taught. Again, the completed test should be reviewed and discussed.

Exhibit 20.–Recommendations to Prevent HIV Transmission Through Shared Drug Injection Equipment

All drug abusers should be aware of the potential for acquiring HIV infection and AIDS from sequentially using (sharing) injection equipment and paraphernalia and through sexual activity.

- Persons with a *negative HTV antibody test* should be counseled to reduce their risk of acquiring HIV infection through sharing injection equipment by the following means:
  - Abstain from any further use of drugs by injection. This eliminates any new risk of bloodborne infections. Drug abuse treatment should be sought to aid in stopping drug use.
  - Do not share injection equipment with anyone. This further protects the drug user from con tracting HIV infection. Care should be taken not only with needles and syringes but also with cotton balls, cookers, wash bottles, or any other materials possibly containing blood.
  - If you continue to share injection equipment, disinfect between uses. While it is not foolproof, boiling needles and syringes for 15 minutes is one way to sterilize equipment between uses; however, boiling plastic equipment may alter the shape and utility of the syringes. Cleaning i njection equipment with disinfectants, such as bleach, does not guarantee that HIV is inacti vated. DISINFECTANTS DO NOT STERILIZE EQUIPMENT. However, consistent and thor ough cleaning of injection equipment with disinfectants such as bleach should REDUCE trans mission of HIV if equipment is reused or shared.
  - To maximize the effectiveness of cleaning, needles and syringes should be flushed with water, preferably soon after use, before blood has time to clot in the needle and syringe. Continue f lushing until the equipment is at least visibly clear of blood and debris. The use of soapy water and agitating (tapping, shaking, or “plucking”) the equipment while cleaning may be helpful in removing blood and debris. The equipment should then be FILLED with fuil-strength house hold bleach for at least 30 seconds of contact before again rinsing with water. Even apparently clean equipment should be bleached before use unless it is known to be sterile. Bleach, which is highly corrosive, may alter the usefulness of the equipment.
- *Infected persons* should be counseled to prevent further transmission of HIV by the following means:
  - Inform prospective drug-using partners and sexual partners of their infection so they can take appropriate precautions. Clearly, abstaining from drug injection and sexual activity with an other person is one option that would eliminate any risk of HIV transmission by those routes.
  - Protect a partner during any drug use by taking precautions, as suggested above.
  - Since reinfection and/or infection with another strain of HIV may contribute to disease progres sion, HIV-infected drug users should refrain from reusing or sharing injection equipment to protect their own-health as well as that of others.

Source: Adapted from Centers for Disease Control and Prevention 1986.

HIV Antibody and Hepatitis B Testing

Patients manifest varying degrees of acceptance of HIV counseling and tests. Some patients are highly motivated to learn their serostatus, while others may be wary or suspicious. Still others may not perceive themselves to be at risk for HIV infection and consider the test unnecessary. The therapist's role is to -

- Improve the patient's self-perception of risk.
- Support behavior change already attempted.
- Negotiate a risk-reduction plan.
- Support decisionmaking about the antibody test.
- Help patients who test positive to deal with the results.

Provide Information

If patients express interest in being tested, provide them with the names of one or more testing facilities and their addresses, telephone numbers, and hours of operation. Also explain the agency's testing procedures, including confidentiality or anonymity policies, and the procedures for and time involved in getting the test results.

Discuss Results

Therapists should volunteer to meet patients at a place of their choosing (a parking lot, a park, the mall) to discuss the test results. If the results are positive, contact tracing can be done if patients so choose. These persons will be informed that someone (the patient will not be identified) they have had sex with or shared needles with during the recent past has tested positive for HIV. They will be given information about what this means for them and how to get tested themselves.

Relationship Counseling

With those who are married or involved in a romantic relationship, CRA + Vouchers focuses on reciprocity relationship counseling. Therapists train couples in the use of general communication skills and the application of those skills to developing behavioral contracts to improve the quality of their relationship. These procedures are based on those outlined by Azrin et al. (1973) and Sisson and Azrin (1989). Interested readers should see those sources and Meyers and Smith (1995) for more information on this approach.

The schedule generally consists of one session each week for 4 weeks and then one session every 2 - 4 weeks for the remainder of treatment, for a total of eight sessions. Each session is about 1 hour long, and many of the major problems in the couple's relationship may be discussed.

The couples sessions replace individual sessions. Therefore, discussion of urinalysis results should be the first topic addressed. If disulfiram is being used, the Disulfiram Assurance Procedure should also be followed in the office.

Session 1

Introduce Relationship Counseling

During the first relationship counseling session, therapists should provide an overview of this therapy and explain that the primary objective is to make both individuals more satisfied with their relationship.

> *"As you well know, an important area of your life that is negatively affected by cocaine problems is your relationship with your partner. Those close to the person with the problem are typically most af fected by the problem. Many partners of cocaine abusers have tried many times to help their mate stop using. Strategies for trying to help vary. Anger and frustration usually build up, and feelings of hope lessness and helplessness sometimes arise. Sometimes attempts to help are met with resentment and anger from the partner with the problem."*
>
> "In this part of treatment, we focus on how cocaine use has affected your relationship and how we can work to increase the positive as pects of your relationship. We also discuss ways that your partner

can assist you in achieving and maintaining abstinence. We hope to be able to help you both deal more effectively with this cocaine prob lem."

"We have found that, where there are drug abuse problems, there are usually communication problems. Usually, we see communication that is filled with anger, silence, apathy, or resentment, and many times partners try to get their needs met outside the relationship. By the time patients come to see us, there is little, if any, enjoyment left in their relationship."

At this point, therapists should ask if any of this sounds relevant to their situation and then discuss any issues that arise. After checking for questions and comments, therapists can continue as follows.

"Another major reason we find it important to include partners is that they can provide a source of support that is important for suc cessful treatment. It is essential, as a person begins to stop using cocaine and starts to engage in 'good' behaviors, that they be ac knowledged for doing so. It is sometimes hard for others close to the user to do that because most of what they have experienced during the last months or years is negative emotion and disappointment as far as their partner is concerned. Therefore, if we include the part ners in treatment, they can perhaps empathize with and understand more about what the patient is going through and the effort being given toward treatment. This understanding may make it easier for the partner to provide the support that will be helpful for increasing the chances of recovery."

"Our goals are to help you -

- *Achieve and maintain cocaine abstinence.*
- *Change your current lifestyle.*
- *Increase enjoyment in your relationship.*
- *Learn better ways to solve problems.*
- *Develop effective communication skills."*

"Achieving these goals will not be easy. However, if we all work hard on making changes, the outcome will likely be positive, that is, you will learn how to stop using cocaine and alcohol or other drugs. Our role will be to help you make positive changes in your relationship so that it becomes more meaningful and enjoyable. Like the other areas of change, making changes in your relationship will require much work. You will have to learn and practice new ways of communicat ing and problemsolving. With such practice, we expect that you will learn how to use your new skills to increase the satisfaction you get from your relationship."

"Before beginning relationship counseling, it is important to note that blaming one another will not be helpful. Each of you is always

responsible for your own behavior. Cocaine use is your (the patient's) problem, and you are responsible for your choice to use or not. You (the partner) are responsible for your behavior as well and whether or not you do things that make it easier or harder for your partner to stop."

"There are many causes of cocaine abuse, so it does not help to blame one thing or event. Genetics probably play a role, as do family and societal stressors. Whether you consider your problem a disease or a bad habit does not matter when you are trying to stop using. Once your problem exists, the things that cause you to keep using in the here and now must be dealt with to help you stop using. That will be our focus in this program."

After giving this introduction, therapists should ask both patients and partners how they feel about what has been said. Questions about the process, rationale, causes, blame, responsibility, and so forth should be expected and be answered in an empathic manner to reassure couples that counseling can help them.

Introduction Exercise

Next, to break the ice and create a more positive atmosphere, couples can be asked to recount to each other what it was like when they first met and began to spend time together. The rationale for this is to remind them why they chose to be together and what they might like to regain in their relationship. This exercise may provide good ideas for the types of goals to set in counseling to increase satisfaction in the relationship.

Therapists can then begin by asking patients what they liked about their partners, what sort of fun things they did together, and what attracted them in the first place. Therapists should direct couples to speak directly to each other. If either one tries to recount this to the therapist, redirect the person toward the partner. Also, *therapists should remind them that this is a positive exercise; no negative or critical comments are allowed at this point*. This exercise can be embarrassing for some patients and partners, so it is important for therapists to make them feel as comfortable as possible. The exercise is meant to be light and fun. If couples have difficulty participating and cannot think of things to say, therapists should prompt, model, and gently coax them to continue.

After both have taken turns with this exercise, therapists should ask them to do the same thing again, but this time to tell their partners what they like about one another now. The same "rules" should be followed for this exercise, that is, *only positive things should be shared, and each one should talk directly to the partner*. This exercise may highlight how the relationship has changed and may indicate specific, positive aspects that have faded and need to be recaptured.

After this exercise is completed, it is important for therapists to explain that, because of the impact of drug use on their lives, they may not be

communicating with each other the way they did in the past, and that many of the things they liked about their partners may not be apparent now. However, this does not mean that those positives cannot be recaptured with hard work.

Relationship Happiness Scale

At this point, therapists can introduce the Relationship Happiness Scale **(**exhibit 21**)**. This scale is used to assess how happy couples are *currently* with various areas of their lives. Each partner should complete the form independently. Therapists should emphasize that they are to evaluate the problems in terms of current, not past, satisfaction. A list of examples **(**exhibit 22**)** is given to couples to provide them with types of events relevant to each area.

Once completed, therapists should collect the forms and initiate a brief discussion of their responses. Therapists should explain that this happiness scale will be completed at the start of each session to assess changes that occur during treatment.

Daily Reminder To Be Nice

Therapists should next give patients and their partners each a copy of the Daily Reminder To Be Nice Form **(**exhibit 23**)** and explain the rationale for its use.

> *"Many times in relationships, partners begin to take each other for granted. If you think about it, sometimes they treat strangers with more courtesy, respect, or appreciation than they do their own part ners. This situation can be even worse in relationships that are stressed by drug use. Thus, we have created an exercise that can help to reverse the negative behavior that may have become ha bitual in your household. Even if your situation is not as bad as I described, you both could probably still benefit from this exercise. What I will be asking you to do is simply be nice to your partner. This form lists seven ways to do that. The form is supposed to serve as a reminder for you to do more of these nice things and to record how well you are doing with actually engaging in these nice behav iors."*

Therapists should then review the form with the couples, answer any questions they may have, and ask them to complete a sample form by reflecting back on last week's behavior. Once this is completed and discussed, therapists can ask how the patients would feel if their partners performed these behaviors every day. Again, couples should be instructed to respond directly to one another and to tell each other specifically what they would like the other to do. *The mood during this exercise should be light and fun.*

Therapists should instruct patients to record on the sheet each day whether they performed each of the positive behaviors. A discussion should be initiated concerning where the forms should be kept and how they will remember to fill them out. A good place to keep them is

Exhibit 21: Relationship Happiness Scale

This scale is intended to estimate your current happiness with your relationship in each of the 10 areas listed below. Ask yourself the following question as you rate each area:

How happy am I with *my partner* today in this area? Then circle the number that applies.

Numbers toward the left indicate some degree of unhappiness; numbers toward the right reflect some degree of happiness. By using the proper number, you can show just how happy you are with that relationship area.

Remember: You are indicating your current happiness, that is, how you feel today. Also, do not let your feelings in one area influence your rating in another area.

	Completely Unhappy									**Completely Happy**
Houshold Responsibilities	1	2	3	4	5	6	7	8	9	10
Rearing of children	1	2	3	4	5	6	7	8	9	10
Social activities	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Sex and affection	1	2	3	4	5	6	7	8	9	10
Academic (or occupational) progress	1	2	3	4	5	6	7	8	9	10
Personal independence	1	2	3	4	5	6	7	8	9	10
Partner’s independence	1	2	3	4	5	6	7	8	9	10
General Happiness	1	2	3	4	5	6	7	8	9	10

Name _____

Date _____

Source: Azrin et al. 1973, p. 370.

Exhibit 22: Examples of Relationship-Related Activities

Household responsibilities:

- Yard work
- Cleaning the house, such as sweeping, dusting, and cleaning the bathroom
- Grocery shopping
- Cooking the meals
- Washing the dishes
- Doing the laundry
- Caring for the car

Rearing of children:

- Preparing meals
- Bathing the children
- Disciplining the children
- Watching the children
- Playing with the children
- Helping them when needed

Social activities:

- Going together -
- to the movies
- out to dirmer
- to parties, to night clubs, for walks
- Participating in or watching sporting activities together

Money:

- Having an allowance
- Buying or receiving presents
- Budgeting money
- Saving too little or too much
- Buying clothes and other necessities

Communication:

- Planned discussion periods
- Frequent discussion periods
- Frequent arguments
- The use of tactful statements
- Misinterpretation of things said
- Solving problems through discussion

Sex/affection:

- Frequency
- Location
- Type
- Show of public affection
- Extramarital relationships
- Jealousy

Academic or occupational progress:

- Spends too much or too little time on it
- Meets status expectations
- Too much procrastination
- Constant complaining about the job
- Poor job location

Personal independence:

- Night out alone
- Day off alone
- Lets me drive the car by myself
- Let me learn to drive
- Feel free to ask partner's advice
- Have money easily available without having to ask the partner
- Make household decisions without asking the partner
- Able to go to social events without the partner

Partner independence:

- Partner relies on you for making house hold decisions
- Partner goes out without you, e.g., to movies, sporting events, billiards
- Partner will not go out without you
- Partner makes most of the decisions without consulting you
- Partner is possessive
- Partner is not possessive enough
- Partner lacks friends
- Partner has no personal interests, e.g., hobbies, friends
- Partner does not know how to drive a car

Source: Adapted from Azrin et al. 1973, p. 371.

n the refrigerator or on top of the television set, any place where they can be seen frequently to remind them to do the nice behaviors and to record them.

To make the partners even more aware of ongoing reciprocal behavior, therapists should have them list at least 10 satisfactions their partners are providing to them as well as 10 they provide to their partners. They should be encouraged to refer to specific events rather than general attitudes. For example, "I do laundry each week," "I clean the house,"I provide advice when asked,"I provide moral support,"I went food shopping." After the lists are completed, they should be discussed so agreement is reached and the amount of existing reciprocity is assessed.

After this session, the couple should be given Daily Reminder forms to complete at home before the next session. In addition, they should be instructed to mention each day any novel, unusual, unanticipated, or unscheduled satisfaction they receive from their partners.

Each session thereafter, therapists should review the completed Daily Reminder forms and discuss how the expression of appreciation or satisfaction is going.

Session 2

When couples come in for their next session (and all subsequent sessions), therapists should have them complete the Relationship Happiness Scale and briefly discuss any changes from the last session.

Next, therapists should review and discuss the Daily Reminder forms completed during the days between sessions. Both partners should be encouraged to state specifically what behaviors they engaged in and how they were affected by the other partner's nice behaviors. In this way, the session begins on a positive note. The patients should then be given additional forms and instructed to continue to complete them daily.

If patients and partners did not bring in their forms, or if they did not fully comply with the procedures, a discussion and plan for how to increase compliance should be initiated. Therapists can emphasize the importance of following through with these assignments by reviewing the rationale. Problemsolving techniques and appropriate behavioral procedures should be used to address any compliance-related problems.

Perfect Relationship Form

Next, therapists should give patients and partners the Perfect Relationship form **(**exhibit 24**)** and provide the rationale for its use.

> "We are going to use this form to target areas in which each of you would like to see some changes from your partner. These changes

Exhibit 24: Perfect Relationship Form

Under each area, write down the kinds of activities that would occur in what would be an ideal relationship for you. Be brief, be specific, and state in a positive way what you would like to occur.

In Household Responsibilities, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

In Childrearing, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

In Social Activities, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

In Independence, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

In Personal Habits, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

In Managing Money, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

Other things, I would like my partner to:

1. _____
2. _____
3. _____
4. _____

Source: Sisson and Azrin 1989, pp. 254-255.

should be things that you feel would increase the satisfaction or hap piness you get from your relationship. The exercise is designed to help you identify specific behaviors for change so it will be easier for your partner to know and then respond to your needs. If you don't identify specific behaviors for change, it is difficult for your partner to meet your needs or make you happier. Thus, this exercise will be gin by identifying needs and then will move on to exploring ways to ask for these changes that will increase the chance that your partner actually will make those changes."

Each partner then fills out the first section of the form, "Household Responsibilities." They should list things in this category they would like their partner to do or to do more often. Therapists should repeat the instructions to be specific and to word their requests in a positive manner. Encourage them to be as selfish as possible in stating their wishes and give them an example.

"You would like your partner to help out more with the laundry and vacuuming. Write down: On Saturday mornings after breakfast, I would like it if you would vacuum the living room and our bedroom. Also, on Saturday morning, I would appreciate it if you would gather he laundry from all the rooms and place it in the laundry room."

Next, therapists can work with couples to create specific lists of things each would like the other to do. After completing one or two categories, couples should take the form home, complete it, and bring it back to the next session.

Positive Requests

After patients and partners have completed one or two sections of the Perfect Relationship form, therapists should introduce the notion of positive requests. This component is designed to teach couples how to request things from each other in a way that will increase their chances of getting what they want. The rationale for this component is provided as follows.

"Learning or relearning to communicate positively is important for many couples who come to our clinic, because many times they have stopped communicating as drug use has become prevalent in their lives. Even when there is no drug abuse, it is common for couples to stop using positive types of communication in ongoing relationships. However, if you or your partner want the other to make changes, the most effective way to do this is by using positive communication rather than demanding, nagging, or ordering the other to change."

"We would like to teach you how to use a particular method for making requests that will increase the probability that your part ner will make the effort to change. This type of communication is a skill and, like any skill, requires practice to be able to do it effec tively. Thus, it is important that you both agree to make an effort to learn and practice

these skills. Trying to use this type of communication may be diffi cult at first and may seem forced or unnatural but, over time, you will begin to feel more comfortable."

Therapists then explain that some ways of making a request are more pleasant than others, which, in turn, make it more likely that a request will be acted upon **(**exhibit 25**)**.

- Try to take the other person's point of view and understand how it feels. The other person may not recognize your needs or realize that you are unhappy.
- Try to take partial responsibility. For example, if you want your part ner to take more initiative in helping the kids with their homework, but have never told your partner how important that is to you and why, then you could preface your request by saying, "I know I have never told you how important it is to me for the kids to do well in school, but because of how I failed and how it made me feel so stu pid, I really don't want them to have to feel that way their whole lives. I know it's partly my fault that we don't spend a lot of time with them on schoolwork, but I would like us to begin to do that as much as possible."
- Offer assistance to make it easier for your partner to fulfill your re quest. In the example I just gave, you could remind your partner, if it is the partner's turn to help with homework, that you could arrange or schedule the times for this to happen. In making the request, you could say something like, " Would it be helpful if I..."Would it make it easier for you to do this, if I..."

After reviewing these steps, another one or two examples of a positive request should be provided by therapists, and couples should be encouraged to review these steps before they make a request.

Next, therapists can have each partner take out a Perfect Relationship form and practice making positive requests. Each partner can pick one request to practice. The components of an effective request are reviewed, and therapists help the partners choose words that are specific and positive. Each one then practices making these requests to the other partner.

Couples should be encouraged to try to fulfill each other's desires, at least in part, and to adopt the attitude that any desire can be fulfilled and "If you want it, you can get it."

Techniques for working out compromises should be discussed next. Specifically, couples should be taught to turn a particular request into a continuum rather than an all-or-none request. For example, if one partner wants the other to initiate sexual activity and the other refuses to accept that responsibility, a discussion of exactly how often the

Exhibit 25: Positive Requests

1. State What You Really Want

2. Take the Other Person's Point of View

3. Take Partial Responsibility

4. Offer to Help

5. Always Try to Say Yes, If Possible

6. Look for Compromise, If Necessary

partner wants the other to initiate sex can lead to an agreed-upon compromise.

Any time a request is made by one partner, the other should be asked whether it will be done. If the answer is no, a compromise should be worked out. The partners are encouraged not to refuse requests from one another. Rather than saying no to a request, a partner might suggest an alternative. When proposing an alternative solution, the partners are instructed to follow the same steps used for making a new request.

After compromises are practiced, therapists should ask each partner to pick one request that will be the target for change in the next week. These requests are then directly stated to the partner in the session. The requests can be practiced repeatedly, if necessary, with therapists providing feedback to help shape effective, positive requests. Once the requests are agreed upon, they should be written down in contract form on the request forms shown in (exhibit 26).

In the next session, therapists should express interest in hearing from couples about how things went. Couples should be informed that therapists will be tracking progress with these requests each week. Lastly, patients are asked to complete the rest of the Perfect Relationship form and bring it to the next session. Therapists can again emphasize that these are to be thought of as "perfect" relationship requests, not demands that they are forcing on their partner. Thus, they can be encouraged to be selfish when writing down those things they would like their partner to do.

Session 3

At the beginning of the third session, therapists should review the Daily Reminder forms and have the couple complete the Relationship Happiness Scale. Next, the Perfect Relationship forms should be reviewed. If couples did not complete these forms, they should take a few minutes during the session to do so; at least a significant portion of the form should be completed. Progress on the reciprocal-request contract is then reviewed. If progress was good, therapists should provide social reinforcement. If little or no progress was made, a problemsolving discussion should follow, focused on developing a plan for the coming week that will increase the likelihood of compliance with the request.

Next, therapists and couples target another set of requests for change. The Relationship Happiness Scale is used to prioritize areas for change. For example, areas that patients or partners rate as low in satisfaction are likely to be areas in which therapists encourage them to make changes. Once an area is agreed upon, each partner can pick one request from the Perfect Relationship form. Therapists then have couples practice making positive requests using the steps reviewed in the

Exhibit 26: Reciprocal Contract for Behavior Change

This contract is designed to assist you in achieving and maintaining positive changes in your relationship. During treatment, you will be asked to develop a number of these contracts that document reciprocal changes requested by you and your partner. By making public commitment and putting it in writing, you are actively taking steps toward achieving and maintaining positive changes in your relationship.

I, _____, agree to make every effort possible to make the following change(s) at my partner's request. I understand that this change is very important to my partner and therefore also very important to me.

Behaviorchange:

_____

_____

I, _____, agree to make every effort possible to make the following change(s) at my partner's request. I understand that this change is very important to my partner and therefore also very important to me.

Behavior change:

_____

_____

This contract will continue throughout treatment unless a new contract is substituted or until one or both parties decides to stop participating.

Patient: _____ Date_____

Partner: _____ Date_____

Therapist: _____ Date_____

ast session. Then another reciprocal contract for behavior change is completed and signed.

Usually only one new request for change is recommended each week and, if no progress is made during the week, new requests are placed on hold until couples successfully comply with the first request.

Communications Training

Next, couples are given the Communications Skills Training #1 handout (exhibit 27). The components of positive communication training are reviewed and discussed. These procedures for teaching positive communication skills are based on the approach of Gottman et al. (1976) and McCrady (1986). The Perfect Relationship form is then used to identify areas of their relationship the couple would like to improve. They then pick an area to discuss in session. The rationale for this exercise could be explained as follows.

> *"Like any other skill, developing communication skills takes practice. What I would like you to try to do now is to have a discussion about [name subject area], and while doing so, try to keep in mind the communication skills we just reviewed. During your discussion, I will be interrupting you to point out particular strengths and weaknesses of your interaction in terms of the communication skills. I may show you some other ways to get across your points. I may ask you to try again and practice another way of phrasing something, or practice omitting parts of your comments that are not effective. You may find this exercise a little strange or embarrassing; it may also be quite frustrating. However, I would like you to try to stick with it and even try to enjoy yourself. Learning new ways to communicate is not easy, but the only way to improve and to change old habits is to practice."*

The rest of the session should be used to practice these communication skills. Before leaving, the couple should pick two problem areas they will discuss during the next week, using the communication skills learned. Therapists should encourage them to select a specific day and time to have the discussions and to write down their impressions of these encounters and how they felt they did. Finally, therapists should remind them to continue to complete the Daily Reminder sheets.

Session 4

At the beginning of this session, therapists should -

- Review the Daily Reminder To Be Nice completed in the past week.
- Have the couple fill out the Relationship Happiness Scale.
- Review progress on the reciprocal contract requests.
- Review how the couple fared in the scheduled discussion of the two problem areas.

If there were problems, these should be dealt with. It is important to spend as much time as needed to review, problemsolve, and discuss any relevant issues. If the couple complied well with the reciprocal requests, an additional request should be considered. If it is decided that the couple is going to add another request, the same procedures as in Session 2 should be followed to target and practice this request.

Communications Training

Next, therapists should give the couple Communications Skills Training #2 **(**exhibit 28**)**. The communications skills are reviewed with the couple and the procedures used in Session 3 are used to teach and practice these skills. Again, therapists should provide as much positive feedback as possible as they try to shape effective, positive communication between the couple. With some couples this will be painstakingly slow, so it is important to be flexible and to use a reflective and empathic counseling style and behavioral skills to help the couple comply and progress in this area of change.

At the end of the session, the couple should be asked to repeat the same assignments given in the last session (i.e., discuss two problem areas and practice using the communications skills and complete the Daily Reminder sheet).

Sessions 5 - 8

Throughout the remainder of the relationship counseling sessions, the couple should continue to complete the Relationship Happiness Scale, the Daily Reminder sheets, make reciprocal contract requests, and practice communication skills. Many times, the first few weeks or so of this counseling go very smoothly. Because patients are making an effort that can readily be seen by their partners, many positive changes usually occur. It is important to recognize that this may not last. The old, habitual patterns of communication will most likely surface as stressors occur or if the patient uses cocaine. Therapists should persist in teaching the communication and relationship skills. These are the skills that will help couples get through the difficult times.

The last few sessions should be scheduled further apart (biweekly, then monthly) prior to ending relationship counseling. Therapists should ensure the patients' partners that they are still involved, even if not attending regularly, and that they can contact the therapist any time they feel the need.

Exhibit 27: Communications Skills Training #1

Improving Communication

Below is a list of communication behaviors you may find helpful for improving communication with your partner.

Be polite to your partner. When talking with your partner, use the same courteous words and tone you would use with a stranger or a coworker.

Express positive feelings. Try to let your partner know what you like about things they have done or how they have been acting. Spend at least as much time on the things that are going well as on those that are not.

Do something nice for your partner. Without being asked or without a special reason like a birthday, do something that your partner would like or find special. Do this without asking for or expecting something in return.

Determine the importance of an issue before you complain. Ask yourself whether something is worth complaining about. Don't get into the habit of always complaining about something. Express complaints only about things that matter.

Choose a "good" time to bring up a complaint. Try to pick a time to discuss a problem that will provide a good setting for a positive discussion. For example, make sure you will have some uninterrupted time to discuss it. Don't bring it up when you are really angry. Don't bring it up when your partner is angry.

Have a goal in mind when you bring up a complaint. Give some thought to the problem before you bring it up with your partner. Ask yourself what you would like to get out of it. What changes are you hoping for? Why do you want those changes? Are those changes reasonable or achievable?

Be specific about your complaint. Focus on only one thing at a time. Try to have a very specific example of what you are upset about so you can help your partner understand the issue exactly. You should be able to describe specifically what you would like the partner to do differently. Don't bring up other problems; stay focused.

Request changes in a positive manner. Tell your partner, in the most positive way possible, what is bothering you and what you would like changed. Use the steps outlined in Positive Requests training. Avoid criticisms, put-downs, name calling, and assumptions about your partner's motives.

Prepare to compromise. Prepare yourself to discuss the issue and come up with a solution that works for both of you. Don't use ultimatums or dismiss your partner's ideas.

Disagreements

Below is a brief outline of some important issues and behaviors that may help you through disagreements that arise in your relationship.

Expect to have disagreements. Even in the best of relationships, partners do not always agree. Disagreements are normal parts of a relationship.

Some disagreements are not real disagreements - they are miscommunications.

Miscommunication happens when the message you are trying to send your partner provokes a response that you did not expect or intend the partner to have.

Miscommunications typically result from not expressing yourself clearly, specifically, or completely. Do not make assumptions about what your partner knows or doesn't know. Provide reasons for why you are complaining or making a negative statement. Use the communication skills discussed in Positive Requests training and those listed above.

Intent should equal response. If your message gets a response that you did not intend, assume that something went wrong with the communication process.

The problem may be in the message. You - the message sender - could have said something that you did not intend to by-

- Not saying what you really meant.

- Leaving out information or assuming your partner already knew.
- Giving a nonverbal message that was not consistent with the verbal message (e.g., using a sharp tone of voice because you were in a bad mood).
- Hidden agendas. Unresolved issues may enter into problems any time you get upset; that is, you may have made statements that are not directly related to the problem you were raising.

The problem may also occur with the person who receives the message. Persons receiving the message may also react differently than they intend because of the same types of things that affect the delivery of the message.

Conflicts

Arguing and fighting. Arguing and fighting often occur because the communication skills described above are not being used. For example, if you do not stay on a specific topic, call someone a bad name, bring up every little thing that bothers you, or raise issues at inappropriate times, a fight or argument is likely to arise.

The first step in gaining control of fighting behavior is to **recognize your pattern of fighting**. Fights are defined as bringing up issues without discussing or resolving them. It doesn't matter if people are yelling at each other or not. If there is no resolution and a problem is left hanging, it is a fight. It is important that you learn to identify fights and make a list of what situations typically result in fights with your partner.

Avoidance. Some couples rarely argue. They simply avoid conflict by never talking about issues. In this situation, either one partner usually gives in all the time or both partners become good at ignoring issues. This avoidant style of communication usually results in one or both partners feeling resentful, unloved, not cared for, or unimportant. The communication skills that need to be used are to recognize what issues are important and to communicate these issues to your partner at an appropriate time.

Sometimes it is **hard to recognize whether you and your partner are having problems with avoidance**. Some clues or signals that avoidance may be a problem are-

- You think there is no conflict at all in your relationship.
- Conversations tend to be dull and routine and you don't feel connected.
- You feel that certain topics cannot be talked about because they will start a fight or result in awful consequences.
- You feel resentful toward your partner much of the time and don't want to do special favors.

Exhibit 28: Communications Skills Training #2

Good Listening Skills

Good listening can help couples communicate more effectively. Although you may feel that listening is easy or natural, it isn't. Active listening that involves trying to understand your partner is very difficult. It usually takes some training and practice in listening skills.

Before responding, a good listener will try to -

- Completely understand what the part ner was trying to communicate - what the part ner wants and how the partner is feeling.
- Request the feedback and information needed to accurately summarize what the partner intended to say.

Questions you can use to get such feedback are -

- Are you saying ... ?
- I'm not sure what you mean; can you ex plain that to me?
- How are you feeling now?
- Are you mad or upset with me?
- I don't think I understand your point; can you explain it a little differently?
- Can you give me an example? I'm not sure I understand why you are so upset.

Validation. It is important that you try to validate partners' feelings, that is, let them feel that you think you can understand how and why they feel the way they are feeling. Communicate to them that their feelings make sense. This does not necessarily mean that you agree with them, but that you can understand their point of view. Validating feelings is probably the most important way you can let them know you care about them and the way they feel. It lets partners know that they are important. There are very few other effective ways to convey that message to your partner.

Examples of validating statements are -

- I can understand how you would feel that way, given that ...
- No wonder you feel so angry.
- If that's how you see it, no wonder you are so upset.

Examples of statements that are *not* validating are -

- That's silly.
- You shouldn't feel that way.
- That's ridiculous.
- I don't think that should upset you so much

.

If you can't validate your partner's feelings because you are too upset, take some time to regroup. Suggest a short break in the conversation. Come back when you feel you can validate your partner's feelings.

Poor Listening

A major cause of poor communication is not listening to your partner. Each partner must seek to understand the other. If you don't understand a problem, it is very hard to fix it. If you can't hear and understand your partner's point of view, the problem will never be resolved effectively.

Poor listening usually sends the following messages:

- I am not interested in your opinions or feel ings.
- Your feelings are ridiculous or silly.
- You are foolish to have those feelings.
- Your feelings don't deserve my attention or concern.
- My opinions and feelings are more impor tant that yours.
- My opinions and feelings are more reason able than yours.

Obviously, these messages will not resolve a prob-lem. Most likely, they will cause more resentment, bad feelings, and difficulties.

Identifying poor listening behavior is not always easy. A few things to look for are -

- **Self-summarizing**: You or your partner con tinually restate your position over and over during a discussion or argument.
- **Cross-complaining**: The complaint of one partner is met with a complaint by the other instead of problemsolving the original com plaint. Thus, many old complaints and issues are brought up each time an issue is raised.
- **Mind-reading**: issues are avoided (at least at first) by partners feeling and acting as if they know the other partner's feelings and desires. This results in one partner feeling left out of decisionmaking, unimportant, and re sentful.

Exhibit 28: Communications Skills Training #2 (continued)

Stop Action or Timeout: Dealing With Poor Communication

The **time to act** to prevent or effectively deal with conflict is when you recognize that you are getting a response from your partner that you did not intend to get.

If you or your partner realize that miscommunication has occurred, **one of you should call a timeout or stop action**. You should simply say hold it, timeout, or whatever vou find comfortable. This should signal that it is time to stop the discussion and try to analyze what went wrong.

Once one of you calls a timeout, you should both do the following:

- Find out why your partner is upset or has responded in a particular way.
- Express the message you intended to com municate and specify the response you ex pected.
- See if you can identify anything like voice tone or bad mood that affected the com munication.
- Ask yourselves the following:
- Are there any hidden agendas?
- What was I trying to say? Did I say it in an appropriate manner?
- Was I trying hard to understand my part ner?
- Was I being impolite or just plain stub born?
- Did I demonstrate that I cared what my partner was feeling?

Restart the conversation with the intention of listening to your partner. Use good communication skills to express your feelings. Do not blame each other, and try to identify what went wrong the first time in terms of good communication skills. These steps can be used to guide the timeout:

- Call timeout or stop action.
- Listen for feedback from your partner.
- Try to summarize your partner's viewpoint.
- Try to validate your partner's feelings.

Patterns of Communication Problems

Once you start identifying the communication problems that exist in your relationship, you will probably notice that you and your partner have developed certain patterns or styles that occur time and time again. just like any other behavior, the way you communicate - good or bad - has become a well-Iearned habit. The first step in changing these problematic communication patterns is to label them so you know what you need to deal with. Four common communication patterns that result in conflict are listed below.

Mind-reading. The ineffective communication behaviors that occur when mind-reading is the problem are -

- You think your partner should know what you want or need without asking.
- If you have to tell your partner what you want, you feel it "doesn't count."
- You feel you know what your partner wants or is thinking without being told.

It is unrealistic for you to feel that your partner *should* know what you want or need. It would be nice if they did, but expecting it is a romantic fantasy. Directly communicating your needs, wants, and feelings is necessary for your partner to learn better to provide you with what you need. Similarly, don't assume you know what your partner wants; ask your partner so you can more effectively meet your partner's needs.

Yes, but-ing. If you or your partner have this common communication problem, you will notice that during most arguments or disagreements one or both of you responds to the other's suggestion or opinion by saying, "Yes, but that won't work because..... or 'Yes, but you don't really understand why I didn't do it,' or 'Yes, but we can't do that because..." This type of communication sends the message that you don't want to change or meet your partner's needs or understand the partner's point of view. Instead of yes, but-ing, learn to respond by-

- Requesting more information.
- Suggesting a compromise.
- Saying positive things and being more un derstanding.

Character assassination. Another common communication problem is making change requests or comments that attack your partner's whole self, rather than specific problem behaviors

or areas for change. For example, if you find yourselves making statements like, "Can't you be more like Jim," or "Can't you stop always thinking of yourself," or "Why do you always have to be so stupid," then you are engaging in character assassination. This means you are making impossible demands on your partner or inaccurate critical statements. All this usually does is provoke defensive, aggressive, or hurt behavior from your partner. It also does not let your partner know the specific things you would like the partner to do differently. It is important to learn to make specific change requests rather than global, vague assassinations. Also, it is important for the receiver of the assassination to ask the assassin to be more specific and say exactly what is wanted.

The complaining rut. This problematic pattern of communication describes couples who complain all the time without including any suggestions for change or alternatives. If you hear you or your partner saying things like: "Why do you always have to be so mean" or "Can't you stop coming home late all the time" or "I wish you would stop hanging around with hose folks" or "I wish you would spend more time with the kids," that is a complaining rut. If you make statements like that without including some alternatives or specific requests for change or improvement, then you are in a complaining rut. The problem with this approach is that, when you don't identify alternatives, all you can do is take note when your partner is engaging in the bad behavior again. If you suggest constructive alternatives, you can then take note of when the partner is making that change and feel good about it.

It is important to learn to only make complaints that include specific statements about what you would like your partner to do instead of the problem behavior. For example, instead of just saying, "I wish you would stop hanging around with those guys," you could include, "It would be nice if you spent some time each night with the kids helping them with their homework and maybe on Friday nights we could go out to the movies." Your goal should be to give your partner something specific to try to do so your partner can demonstrate an effort to change.

Other Substance Abuse

The majority of cocaine-dependent individuals abuse other substances as well; approximately 60 percent are also alcohol dependent, and about 30 percent are marijuana dependent. Many others use such substances but do not meet dependence criteria. Since concurrent drug use may influence outcome, any effective treatment for cocaine dependence must address other forms of substance abuse. This chapter provides a general approach to concurrent use of substances other than cocaine and a more detailed approach to handling alcohol and marijuana problems.

General Approach

CRA + Vouchers recommends but does not require simultaneous cessation of all abused substances as a condition of treatment. The philosophy of this approach is to, first and foremost, provide patients with treatment for the specific problem for which they are seeking help - cocaine dependence. Many patients do not consider alcohol or other drug use a problem, or may acknowledge it as a problem but express no desire to change. In general, therapists work toward sustaining and strengthening the patients' efforts to resolve their cocaine problem while, at the same time, trying to motivate them to abstain from use of other substances.

Treatment Goals

Therapists should be clear in their recommendations regarding the benefits of abstinence but should adopt a flexible approach toward patients' use of alcohol and drugs other than cocaine. Dwelling on abstinence issues that patients are not interested in may lead to early dropout. Similarly, overemphasis on other drug use can lead to an adversarial or confrontational relationship between patients and therapists that can interfere with effective treatment for cocaine problems.

(This chapter does not address concurrent abuse of cocaine and opioids, although vouchers are effective with this population (Silverman et al.1996) as is an adaptation of CRA + Vouchers (Bickel et al. 1997). Cigarette smoking cessation is currently not a treatment goal despite the high usage (over 70 percent) in the cocaine-dependent population. However, that policy may change if it turns out that quitting smoking does not interfere with, or perhaps enhances, cocaine abstinence.)

Also, patients who express no interest in abstaining from other substances during the early stages of treatment may change their minds later.

- They may find that they cannot achieve their goal of cocaine absti nence while continuing to use other drugs.
- Their success with cocaine abstinence may be reinforcing and, in turn, may lead them to try abstaining from other substances.
- They may find that the negative consequences they hoped to avoid by giving up cocaine continue because of their drinking or other drug use, leading them to increase attempts to abstain in order to avoid these consequences. Similarly, other drug use may interfere with pa tients' ability to meet their lifestyle change goals because of hang overs, low energy levels, or too little time for positive social activi ties.
- The use of other substances may result in new negative consequences, such as an arrest for driving while intoxicated or possession of mari juana, which change the patients' interest in eliminating other drug use.

A small minority of patients can make progress in discontinuing cocaine use despite using other substances. Therapists can continue to advise total abstinence while accepting the fact that therapeutic goals cannot be dictated to patients. Instead, therapists can engage them in treatment around the issues where there is therapist-patient agreement and attempt to work from there to facilitate more wide-ranging therapeutic changes in the future.

Abstinence

While maintaining a flexible stance toward other drug use, therapists should continue to strive for patient abstinence from alcohol and other drugs. Laboratory research has shown that alcohol, even at relatively low doses, can increase preference for cocaine use over nondrug activities (Higgins et al. 1996). Other drugs may do the same by increasing the reinforcing effects of cocaine, placing patients in closer proximity to cocaine, or directly interfering with the skills needed to successfully avoid cocaine use.

- Patients who stop cocaine use but continue regular use of other sub stances are likely to remain in a cocaine-using environment within the same social network. This would make it difficult for them to engage in new social activities.
- If patients are abusing other substances, the consequences of that use may prevent them from developing the stable lifestyle that is impor tant to maintaining cocaine abstinence. For example, if patients are getting drunk frequently, it is unlikely that their family relationships will improve, that they will maintain stable

employment, or that they will have the time or energy to engage in regular activities unrelated to alcohol abuse.

Reduced Use

Many cocaine-abusing patients are not interested in stopping their use of other drugs or alcohol, even after being given good reasons for doing so. For those patients, the next alternative is to try to set reduction and safe-use goals for the other substances. If patients are willing to work on these reduced use goals, therapists can help them set appropriate goals and teach them self-control skills to increase their ability to achieve those goals. Abstinence from all illicit drug and alcohol use is recommended; however, with patients who refuse that goal, therapists should seek to facilitate at least some movement in a therapeutic direction.

No Intervention

For patients who also refuse reduction goals, therapists should proceed by targeting cocaine only, while monitoring use of other substances. Continue to counsel these patients toward abstinence and reduction goals but, if they refuse, do not provoke a confrontation or discontinue treating their cocaine dependence.

Concurrent Alcohol Use

Alcohol is the substance most commonly used or abused in combination with cocaine. Many patients report that they almost always drink alcohol either before, during, or after cocaine use (Higgins et al. 1994c).

- Alcohol is their primary drug of choice.
- They like the high associated with the combination.
- Alcohol helps them counteract cocaine-induced anxiety.
- Alcohol helps relax them.
- Alcohol makes them more sociable.

Some patients report that they do not drink very often and that alcohol is not a problem. Others say they only drink when they use cocaine, whereas some report that they only use cocaine when they drink. Because of this high incidence of alcohol use associated with cocaine dependence, disulfiram therapy is included as a component of CRA + Vouchers.

The general strategy for dealing with alcohol use is as follows.

- If patients meet criteria for alcohol abuse or dependence, strongly recommend abstinence and encourage them to agree to monitored disulfiram therapy. Also focus on behavioral strategies targeted to abstinence.

- If patients do not meet criteria for alcohol abuse or dependence but a positive relationship exists between their alcohol and cocaine use, recommend abstinence with monitored disulfiram therapy and be havioral strategies.
- If patients will not agree to abstinence as a goal, encourage them to reduce drinking and restrict it to safe circumstances. Ask them to agree to a backup contract which states that they will initiate disul firam therapy if they cannot meet their limited drinking goals.
- Patients should not be discharged or terminated because they refuse to cease or reduce alcohol use or are unable to meet alcohol-related goals.

Abstinence

A combination of behavioral interventions and monitored disulfiram therapy should be provided to patients who agree to set abstinence goals. The behavioral interventions used for cocaine abstinence have been successfully applied to alcohol abstinence; the voucher program is generally not used. The disulfiram procedures should be used with all patients who agree to take this medication.

What Is Disulfiram?

Disulfiram, often sold as Antabuse, is an alcohol-deterrent medication that inhibits the liver enzyme aldehyde dehydrogenase, which assists in the breakdown of acetaldehyde, the major alcohol metabolite (Fuller 1995). Consuming alcohol while disulfiram is in the body causes an accumulation of acetaldehyde, which produces an unpleasant physical reaction. Symptoms can include flushing, rapid or irregular heartbeat, dizziness, nausea, vomiting, difficulty breathing, and headache. This reaction can be medically dangerous, especially in individuals with certain preexisting health conditions. Thus, the medication is available only by prescription, and disulfiram therapy can only be used in collaboration with a physician.

Medical Oversight

The disulfiram protocol must be administered under medical supervision. If a clinic physician is unavailable, disulfiram therapy must be handled by a referral to the patient's family physician or, preferably, by a community physician who is informed about substance abuse and the utility of disulfiram therapy.

It is prudent to work out, in advance, with one or more community physicians, a protocol that facilitates referral, workup, and initiation of disulfiram therapy. Before the first dose of disulfiram is given, it is essential that medical personnel determine the patient's baseline meas-ures. Patients are then monitored regularly for any serious deviations from their normal state.

Disulfiram Protocol

The following disulfiram protocol has two elements. First, therapists must educate appropriate patients about disulfiram therapy. If patients are interested in trying disulfiram therapy, then plans to support medication compliance are developed.* Therapists should discuss disulfiram with appropriate patients early in the treatment process.

Introduce Disulfiram

The topic of disulfiram therapy can be raised with appropriate patients in the manner described below.

- Bring up the topic of alcohol use. Review the patients' history of alcohol-related problems, using information obtained in the intake assessment. During this interaction, elicit patient feedback and con firmation.
- Recommend that patients consider disulfiram therapy and give the rationale for doing so. Find out what the patients know about disul firam. If they have sufficient knowledge about disulfiram, acknowl edge that and offer a brief review. If they are unfamiliar with disul firam, then request a few minutes to explain.

"Disulfiram comes in a pill that looks like an aspirin. If you take it daily, it usually has no effect on you, unless if you drink alcohol. If you drink alcohol for up to 14 days after taking disulfiram, you will get sick. Disulfiram can help you refuse to drink because you know alcohol will make you sick. It works by preventing the alcohol you drink from being properly processed in your body. Usually, the alcohol is digested or processed by different enzymes which break it down into a form your body can tolerate. Disulfiram prevents this from happening, which results in your feeling sick."

"If you drink when you are taking disulfiram regularly, you will start to feel sick in about 5 minutes. You will flush, become nauseous and sweaty, and your heart rate will speed up. This reaction depends on how much you drink. The more you drink, the worse the reaction gets. If you continue to drink, or drink a large amount at once, such as four or five beers or shots, you will probably vomit and feel like you might faint."

"Because disulfiram's effects can last up to 2 weeks after taking the last pill, it can really help individuals who have mixed feelings about drinking or who tend to drink impulsively. If you were to feel like drinking one day just out of the blue, or for some specific reason, disulfiram can give you a reason not to drink. It also can buy you some time to change your mind again before you do decide to drink."

"Disulfiram therapy also gives you a way to seek help or advice before you decide to drink again. In disulfiram therapy, we can involve

*The procedures discussed here were adapted from Sisson and Azrin 1989.

another person in your life to assist you in taking disulfiram at home. You can take your disulfiram at our clinic on the days you come for urinalysis testing. If you feel like drinking, you will want to stop tak ing your disulfiram, and you will have to discuss this with someone. You can talk about what you are feeling and perhaps find another way to deal with whatever causes you to want to drink."

- Explain the importance of alcohol abstinence. Do not use the term alcoholic. Explain that while alcohol may not be a major problem, it may interfere with their efforts to stop cocaine use. Describe what has been learned about the adverse effects of drinking on cocaine use, that is, that even modest amounts of alcohol can increase co caine use. Discuss the benefits of disulfiram.

- Taking disulfiram assures those around you that you're not drinking and that you have made a strong commitment to abstain from alco hol and cocaine use.

- Disulfiram may help your family or friends trust and work with you.

Compliance Procedures

Those patients who are interested in trying disulfiram therapy should review and sign the consent form (exhibit 29) and meet with the supervising physician to obtain medical clearance. When everything is approved, patients should be given written information to take home

Exhibit 29: Disulfiram Consent Form

By accepting disulfiram therapy, I acknowledge the need for assistance in solving a drinking problem. I also understand that, with my full cooperation in this therapy, I am most likely to achieve successful recovery. It has been explained to me and I understand the effects which disulfiram can trigger if I should consume even a small amount of alcohol in any form. These symptoms include flushing, nausea, vomiting, thirst, low blood pressure, and possible convulsions. I understand the this reaction may occur up to 2 weeks after I discontinue disulfiram. It has also been explained to me that the safe use of this drug in pregnancy has not been established. I understand that sexually active women taking disulfiram should be practicing a medically effective, reliable method of birth control. I understand that if I were to become pregnant, it is recommended that I terminate disulfiram therapy.

Signature: _____

Witness: _____

Date: _____

about the disulfiram protocol. A booklet, “Disulfiram Guidelines,” is available free from Wyeth-Ayerst Laboratories. If this is used, therapists could then have patients take the disulfiram quiz and complete the medical ID card that comes with the booklet.

The following disulfiram assurance procedures are recommended when an appropriate spouse or significant other is available.

Show the patients (and their partners, if present) what disulfiram looks like. Demonstrate how you would like them to take the disulfiram. Crush it in a ceramic cup and mix it with some warm water. Add a few ounces of juice, stir it, and have the patients drink it.

Provide encouragement and support if patients have difficulty decid ing to drink the disulfiram. Once patients have ingested the medica tion, offer praise (and instruct the partner, if one is participating, to do so as well). Therapists can make positive statements like: “That was a big step”

You should feel proud of making such a commitment” or just “Con gratulations on making a new start.”

After drinking the disulfiram, it is important for therapists, patients, and partners to take some time to work out the logistics of the com pliance procedures.

- Instruct patients and partners that disulfiram will be taken at the clinic on urinalysis-test days and clinic staff will be their compli ance partner. Also, let patients know that the disulfiram prescrip tion will be kept at the clinic, and each time they come to treat ment, they will take disulfiram and receive the appropriate num ber of doses to be taken at home.

- Decide on a time and place to take disulfiram daily when it is taken at home. Suggest times such as before going to bed, before dinner, before breakfast, or at lunch. Try to find a regularly occur ring event that can be paired with disulfiram ingestion.

- Discuss the importance of reinforcing disulfiram ingestion. Dis cuss a reciprocal contract in which patients agree to take the disul firam and partners agree to do something to reinforce compliance, such as verbal praise, which is the simplest form of reinforcement. Emphasize to partners that reminding patients of the importance of disulfiram can help with compliance.

- Complete the Disulfiram Contract **(exhibit 30)**; indicate the time of administration, number of days it is in force, place of adminis tration, and nature of reinforcement provided in response to tak ing the disulfiram.

Exhibit 30: Disulfiram Contract

I, _____, agree to take disulfiram at the regularly scheduled time outlined below. I agree to do this for _____ days. After this time, I agree to talk to my therapist and to discuss whether or not to continue taking disulfiram. I also agree to have the person designated below witness the administration of the disulfiram each time it is scheduled.

I, _____, agree to be present and witness each take-home administration of disulfiram.

Time: _____

Days: _____

Where: _____

In response to _____ taking disulfiram as scheduled, I agree to_____ as a means of reinforcing the taking of disulfiram.

_____ _____

Patient's Signature Partner's Signature

_____ _____

Therapist's Signature Date

- Therapists should then discuss potential problems, that is, under what circumstances might patients feel like drinking and not taking their disulfiram. Preface this with an acknowledgment that this is some times hard to talk about but is normal and to be expected. Discuss ways that significant others can help support disulfiram therapy. Also ask patients how they would like clinic staff and significant others to respond if they want to discontinue disulfiram. Remind them again that disulfiram will stay in the system for up to 2 weeks and that they cannot drink during that period.
- Next, engage patients and partners in role-playing on how to handle common problems. If no partner is involved, therapists and patients should role-play the patients' refusal to take the disulfiram. If a part ner is involved, training and instruction in positive communication techniques should be used to help with appropriate responses to a decision to discontinue disulfiram.

Exhibit 31: Therapist's Disulfiram Checklist

____Arranged the patient's baseline disulfiram checklist with clinic staff *before* the patient received the initial dose of disulfiram.

____Reviewed disulfiram instructions with the patient and gave the patient a copy of an information sheet to take home; informed the patient that side effects will be monitored on a regular basis by clinic staff.

____Reviewed the consent form with the patient, obtained patient's signature, and gave a copy of signed form to patient.

____Gave the patient written information for disulfiram users and had the patient complete an identification form and place in wallet; instructed the patient to read booklet at home.

____Negotiated a timeframe of___ days for disulfiram therapy with patient; completed the disulfiram contract with patient (and partner, if applicable) and gave patient a copy of signed form.

During role-play, therapists should model effective responses for the partner.

"I know this is difficult for you and that you are under a lot of stress, but since you have been taking disulfiram and not drinking or using cocaine, we have gotten along so much better. I really like being around you when you're not high or drunk. Is there something I can do to help you, so we can keep things the way they are since you stopped drinking? Perhaps we could go to the movies, or you could go out and exercise? It would make me feel so much better if you took your disulfiram."

Therapists should have patients and partners practice until each one feels comfortable in making effective responses.

- Therapists should also facilitate a behavioral rehearsal on what to do when partners do not want to be part of this procedure any longer. Using modeling and constructive feedback, therapists and partners should role-play possible scenarios in which the partners refuse to participate in the disulfiram plan. This may occur because patients have used cocaine or couples have had an argument. Therapists should instruct patients to still take the disulfiram in front of their partners, even if the partners refuse to participate.
- Therapists should instruct patients and partners to call the clinic promptly any time either of them does not wish to participate in the disulfiram therapy.
- Congratulate patients on taking a big step toward successful resolu tion of their alcohol and cocaine problem.
- Complete the therapist's disulfiram checklist (exhibit 31).

Limited Alcohol Use/Safe Drinking

Goals for reducing alcohol use and restricting use to safe environments can be set with patients who refuse an abstinence goal. Therapists can help patients develop reasonable goals and teach patients self-control strategies to achieve them. Miller and Munoz's (1982) text, "How to Control Your Drinking," contains a detailed description of the protocol.

Examples of typical goals and the clinical strategies that can be used are -

- Limit the amount of alcohol consumed on any given day.
- Limit the number of days in which alcohol is consumed.
- Limit drinking to safe environments (e.g., only in the home, with spouse present, only at restaurants when accompanied by partner).

Strategies to help achieve these goals include -

- Stimulus-control training.
- Drink substitution.
- Drink-refusal skills.
- Self-monitoring and significant-other monitoring.
- Contingency contracting.

Patients who are unable to meet their reduction goals can be encouraged to set abstinence goals and initiate disulfiram therapy. Obtaining a backup contract can facilitate the transition to an abstinence goal. If patients continue to refuse to set an abstinence goal after failing with their limited drinking goals, continue to work with and counsel them toward abstinence.

Patients Who Hesitate or Refuse

The goal with patients who at first refuse disulfiram is to motivate them to at least sample it for some specified time, perhaps only for a week or a few days. Begin by requesting that they take disulfiram for the entire treatment period but negotiate from there as necessary.

> *"How about 30 days? Give us 30 days of no drinking by taking dis ulfiram so we have at least a month to work with you without alcohol being a problem. This way you will be able to focus more on making the lifestyle changes that are important to stopping cocaine use. This doesn't mean that you can never drink again. It just means that you with your goal of staying off cocaine."*

Patients may refuse or hesitate because they want to succeed on their own or by willpower. If this is the case, let patients know that by taking disulfiram they are doing it on their own.

> *"You are the one who has to take the pill. You are the one actively doing something to stop cocaine use and drinking. I think you are doing it the smart way - you are taking steps to control the problem before any more difficulties occur. You are not just talking about it, you're taking action."*

Another approach is to ask partners how disulfiram therapy would make them feel. Have them tell the patients directly and in a positive manner why they feel that way and the potential benefits they see in disulfiram therapy. If patients still refuse, suggest that it is going to be more difficult to achieve a successful outcome without disulfiram. However, do not push. Use clinical judgment to ensure that patients do not drop out of treatment. Remember, patients are seeking help for cocaine dependence,

ot alcohol. If patients are adamant, relax and move on to another topic.

Backup Agreement

For patients who do not agree to take disulfiram, try to obtain a Backup Disulfiram Agreement **(**exhibit 32**)**. This agreement should clearly state that patients will take disulfiram if drinking remains a problem or cocaine use occurs in a drinking context. Here you must work closely with any partner who is involved, so that all parties understand the agreement. If patients agree to this, have them sign the written agreement.

If patients do not agree to sign a Backup Disulfiram Agreement, therapists should move on and not dwell on this issue. If alcohol use continues to be a problem, the suggestion of disulfiram therapy should be raised and discussed with patients in a supportive and caring manner on a regular basis.

Exhibit 32.– Backup Disulfiram Contract

It has been shown that alcohol abstinence aids in remaining cocaine abstinent. Disulfiram is an effective aid in achieving alcohol abstinence. By choosing to take disulfiram, I make a choice not to drink.

With that in mind, I,_____, agree that if I provide a positive urine sample for cocaine, fail to provide a scheduled sample, or drink to intoxication, I will start disulfiram therapy.

If any of the above occur, I agree to take disulfiram for _____ days. I will follow the procedures for taking disulfiram observed at the clinic and on my own on nonclinic days, and I will comply with blood work as required.

In order to be cleared by a physician to take disulfiram, I will make an appointment with the designated staff for a medical update, and I will complete the laboratory work, if needed, as soon as possible.

Patient Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Marijuana Use

Marijuana use, like alcohol use, is common among persons presenting for treatment of cocaine dependence. Common reasons given for the use of marijuana by cocaine abusers are similar to those given for

nalcohol use: enjoy the high, counteract cocaine-induced anxiety, relieve cocaine-induced depression, and as a substitute when cocaine is scarce. There are large individual differences in the frequency and pattern of marijuana use among patients. As with alcohol, staff should assess and make recommendations based on whether marijuana use seems to be related to cocaine use, not on whether patients meet criteria for abuse or dependence. Consideration should also be given to how marijuana use might interfere with other lifestyle change goals. Marijuana use has rarely been observed to be a direct antecedent of cocaine use.

Some individuals can use marijuana regularly without adversely affecting cocaine abstinence (Budney et al. 1991, 1996). Not surprisingly, many patients are not interested in discounting marijuana use. Nevertheless, abstinence from marijuana is recommended for all patients.

The general strategy for dealing with marijuana use is as follows.

- Recommend abstinence and offer to assist patients in applying the strategies targeting cocaine use for marijuana abstinence as well.

- If patients refuse abstinence as a goal, encourage them to reduce their use through the various treatment strategies used for cocaine and al cohol use.

- Never discharge or terminate patients because they refuse to cease or reduce marijuana use or are unable to meet marijuana-related goals.

Other Psychiatric Problems

The clinical focus of CRA + Vouchers is on resolving cocaine abuse. Other psychiatric problems are only addressed when they appear to keep patients from achieving or maintaining cocaine abstinence. The symptoms that most commonly interfere with treatment are related to affective and anxiety disorders. These are addressed with behavioral interventions and, when appropriate, referrals for additional care.

When patients exhibit psychiatric problems that have no apparent relationship to cocaine abstinence but are of concern to them or the staff, they should be referred elsewhere for treatment of those problems. Patients with psychosis and dementia have so far been excluded from CRA + Vouchers treatment, so no data are available about treating them for cocaine problems.

Depressive Symptomatology

The majority of cocaine-dependent patients enter treatment reporting clinical levels of depressive symptomatology. In most cases, these symptoms appear to be a consequence of cocaine and other substance abuse and dissipate precipitously with several weeks of treatment. For approximately 10 percent of patients, depressive symptoms continue to be a significant problem despite abstinence. The following protocol was developed for treating that subset of patients. This protocol should be used in conjunction with, rather than as a substitute for, an appropriate referral for evaluation for pharmacotherapy or other medical interventions.

Evaluate Suicide Risk

If there is any indication of suicidality, a supervisor or clinician trained in assessing suicide risk should be informed and meet with the patient. If suicide risk is high, patients should be referred immediately for further evaluation.

If patients are not an imminent threat for suicide, therapists should proceed with treatment as usual, but evaluate suicide risk at each patient contact. This evaluation should include standard clinical questions used to assess suicide risk. If possible, therapists should obtain

written agreements from patients to engage in "safe" behavior, which includes agreeing to call the therapist or designated agency (e.g., crisis clinic) if feeling suicidal. Therapists should keep the supervisor informed of any changes related to suicidal status. Any time therapists feel uncomfortable about a patient's level of risk, the patient should be referred to an appropriate service.

Monitor Symptoms

The intake assessment should identify patients with depressive symptoms. Those who score high on tests such as the BDI or have a history of depression should be monitored throughout treatment. The BDI can be administered every 2 weeks until the score falls into the normal range, after which it can be administered monthly. Most patients who comply with their treatment plan for cocaine dependence show significant drops in their depression scores.

Treatment

A decision to intervene with depression is typically not made until patients have achieved a relatively stable period of abstinence from cocaine as well as any other drugs or alcohol (usually 2 to 4 weeks). However, in some cases, when patients continue to use cocaine and depression appears pervasive, treatment directly targeting depression may be initiated before abstinence is achieved.

Depression can be targeted in two ways.

- Patients can be given a copy of the book "Control Your Depression" by Lewinsohn et al. (1986). Therapists and patients then systematically work through the chapters in the book in the manner suggested by the authors. The theoretical basis for this treatment is that depression is associated with a low density of positive reinforcement and a high density of aversive events. The primary therapeutic goal is to help patients alter their environment to increase the density of reinforcement and decrease aversive events. This treatment is readily integrated into the CRA + Vouchers approach because it involves similar components and behavioral targets.
- Patients can be offered a referral for evaluation for pharmacotherapy for depression.

Anxiety

As patients try to implement needed lifestyle changes, they may exhibit various levels of social anxiety about meeting new people, dating, and so forth. If the social anxiety interferes with treatment goals, therapists should provide a combination of social-skills and relaxation training. In addition, a number of patients complain about persistent insomnia, which can also be treated by behavioral methods.

Relaxation Protocol

Relaxation training can be used in the context of CRA + Vouchers to reduce anxiety that interferes with patients' ability to develop a new social network, to cope with restlessness that may contribute to insomnia, and for general stress reduction.(This relaxation training protocol was adapted from McCrady 1986 and Goldfried and Davison 1994.)

Therapists should begin by discussing with patients how learning to relax is an effective way to cope with their anxiety. The rationale should be tailored to the patients' situations.

> *"If you find that anxiety is preventing you from meeting new people or going to new, drug-free social settings, relaxation skills may help you overcome these barriers to change. Relaxation skills can be used in the same way you have used alcohol, cocaine, or other drugs to deal with these social situations. You can learn to feel more relaxed and confident and to be more effective in social situations."*

After discussing the rationale, therapists should emphasize that relaxation is a skill that patients develop through practice. Learning to relax, like any other skill, takes time to learn, and it will take awhile for them to become "good" at it. With practice, however, they will be able to use their new skill effectively in many situations that are relevant to their cocaine problem.

Relaxation Exercise and Practice

Therapists should use guidelines and instructions, such as those developed by Goldfried and Davison (1994), to teach patients progressive muscle relaxation skills. During the session, therapists should guide patients through a relaxation exercise. Audiotapes of the exercise can be made so patients can take them home and practice this new skill. Patients should be instructed to practice twice a day, if possible. Therapists should provide patients with self-monitoring forms for recording how relaxed they feel after each practice.

At the next session, therapists should take patients through the relaxation exercise again, providing feedback if necessary and soliciting comments and suggestions from them. Relaxation can be induced in many ways, and patients may have important input on what works best for them (e.g., music, meditation). Therapists need to be flexible about procedures and practice, while emphasizing regular, frequent practice.

After 2 to 3 weeks of practice, patients should feel fairly comfortable with the relaxation procedures. It is important to reemphasize the need for practice. Only by continued practice can these skills be applied effectively in daily life.

Once patients report feeling confident in their ability to relax during the practice exercise, therapists should discuss learning to relax more quickly. Discuss the notion that now that they and their bodies have learned what it feels like to relax, it will be much easier to relax on

command without going through a 10 - 15 minute relaxation induction procedure.

Have patients try to relax in the office without using the tense-relax techniques they have learned. Instruct them to simply command their body to relax and then briefly scan each muscle group to check and facilitate relaxation. Add that this brief kind of relaxation can be very useful in many situations. Have them try this once more in session and discuss how it feels. Again, therapists should emphasize the need for practice and how with practice they will become very good at this.

Therapists and patients should set a goal to practice this brief type of relaxation during the upcoming week. Patients should be encouraged to try it as many times each day as possible. Reminder prompts should be also discussed, such as the use of a wristwatch that beeps on the hour. Each beep can cue patients to engage in the brief relaxation exercise.

Applications

After patients become fairly proficient with this new skill, therapists can begin to discuss specific applications of relaxation training. Therapists should review the patients' functional analysis of cocaine use to identify situations in which relaxation might serve as an alternative to cocaine use, as a means of avoiding or preventing a trigger from occurring, or in some other way help to reduce cocaine use. Therapists should also look for areas in the patients' lives, such as the job site, while parenting, or in social situations, where relaxation might improve functioning and lead to less stressful and more pleasurable nondrug experiences.

Specific goals for using relaxation that are tailored to the patients' situations should be set for the upcoming week. Patients should choose one or two situations (triggers or stresses) in which to try the relaxation skills. These goals should then become part of the active treatment plan and modified as needed throughout treatment.

Insomnia Protocol

A common symptom that occurs following discontinuation of cocaine use is insomnia. It is important to deal with insomnia if it persists, because a regular sleep pattern is essential to good physical and mental health. For patients, persistent insomnia is likely to interfere with making the lifestyle changes deemed important to abstaining from cocaine use.

Therapists should consider using a behavioral intervention for any patient who reports significant sleep difficulties that do not subside after 2 - 4 weeks of treatment. The one described here is based largely on the effective protocols of Lacks (1987) and Morin (1993). Therapists who implement this protocol should consult one or both of these exellent resources.

Rationale Therapists should give patients an explanation and rationale for the sleep protocol.

> *"To help with your sleep difficulties, we can provide a treatment that is consistent with the other parts of your treatment program. This treatment has been widely tested and shown to be effective. We will try to teach you to sleep better by having you -*
>
> - *Learn more about sleep.*
> - *Keep a record of your sleep patterns.*
> - *Learn to use what we call 'stimulus control' procedures to teach yourself to sleep on a regular schedule.*
>
> *"Like other aspects of your treatment, this sleep program will in volve learning and practice. You will learn to -*
>
> - *Go to sleep rapidly once you go to bed by practicing not doing anything else in bed except sleep.*
> - *Use the feeling of sleepiness as the cue to go to bed.*
> - *Stop doing things that are associated with staying awake.*
> - *Keep a regular sleep schedule."*
>
> *"These procedures should result in good sleep habits which will lead to better sleep. Developing these habits will take much planning and practice on your part. However, if you can follow through with what you learn, you will sleep better and will have a skill you can use for the rest of your life."*
>
> *"Most likely, it will take 4 weeks for you to see any benefits from the sleep program. You may experience continued difficulties for the first few weeks. You may even have additional problems and feel worse. So, it is important not to be in too much of a hurry to sleep better, for like any other skill, it takes time and practice to improve."*
>
> *"These new habits may seem difficult to develop at first, but you will become more comfortable with the procedure with repeated prac tice. Expect to be up numerous times in the beginning. You will prob ably even feel worse after the first week of following these steps. However, teaching your body that the bed is for sleeping, not for worrying, tossing and turning, reading, or other activities, is prob ably the most important part of this treatment."*

Sleep Diary Next, explain in detail the importance of keeping a weekly sleep diary **(**exhibit 33**)** and provide patients with a copy. Explain to patients that an important part of building new and better sleep habits is closely monitoring sleep-related behaviors to identify and strengthen cues that are associated with falling asleep quickly, and to identify and weaken those cues associated with staying awake. The sleep diary provides an

inexpensive, nonintrusive, and efficient method of measuring the experiential component of insomnia.

Therapists should then show patients how to use the sleep diary.

> *"You are to record, soon after waking up, your estimates of how long it took to fall asleep, how many hours you slept, how difficult it was to fall asleep, and the quality of your sleep. It is important to find a place to keep this form so that you remember to complete it each morning for the next week."*

Throughout treatment, patients should closely monitor and chart their sleep-related behaviors.

Sleep-Hygiene Rules

Therapists should next introduce the notion of sleep hygiene and give a copy of the six rules **(**exhibit 34**)** to patients. These rules should be presented as important suggestions that, if followed, can help improve the sleep pattern. Therapists should be familiar with the rationales for

Exhibit 34: Sleep Hygiene Rules

Rule 1	Do not drink alcohol later than 2 hours prior to bedtime.
Rule 2	Do not consume caffeine after about 4 p.m. or within 6 hours prior to bedtime. Learn all the foods, beverages, and medica tions that contain caffeine.
Rule 3	Do not smoke within several hours prior to your bedtime.
Rule 4	Exercise regularly. The best time to exercise is in the late afternoon. Avoid strenuous exertion after 6 p.m.
Rule 5	Use common sense to make your sleep environment most conducive to sleep. Arrange for a comfortable temperature and minimum levels of sound, light, and noise.
Rule 6	If you are accustomed to it, have a light carbohydrate snack before bedtime (e.g., crackers, graham crackers, milk, or cheese). Do not eat chocolate or large amounts of sugar. Avoid excessive fluids. If you awaken in the middle of the night, do not have a snack then or you may find that you begin to wake up habitually at that time feeling hungry.

these rules, as discussed by Lacks (1987) and Morin (1993). It is important for them to take the time necessary to explain the rationale for each rule and be able to respond to patients' questions and concerns.

Sleep Restriction and Stimulus Control

After the sleep-hygiene rules are reviewed and plans are made to practice them, therapists should discuss sleep-restriction and stimulus-control strategies (exhibit 35) and give patients a copy. Again, it is important that therapists be familiar with the rationales behind these recommendations and be able to explain them for each instruction and respond to all concerns expressed by patients.

Exhibit 35: Sleep-Restriction and Stimulus-Control Instructions

- Do not go to bed until you are sleepy,
- Get up at approximately the same time each morning, including weekends. If you feel you must get up later on weekends, allow yourself to arise a maximum of I hour later.
- Do not take naps.
- Do not use your bed or bedroom for any activity other than sleep or sexual activity. You should not read, watch television, talk on the telephone, worry, argue with your spouse, or eat in bed.
- Establish a set of regular presleep routines that signal that bedtime approaches. Lock the door, plug in the coffee machine, brush your teeth, set the alarm, and perform any other behav iors that make sense for this time of night. Use your preferred sleep posture and favorite pillows and blankets.
- When you get into bed, turn out the lights with the intention of going right to sleep. If you find you cannot fall asleep within a short time (about 10 minutes), get up and go into another room. Engage in some quiet activity until you begin to feel drowsy and then return to the bedroom for sleep.
- If you still do not fall asleep within a brief time, repeat the previous step. Repeat this process as often as necessary throughout the night. Use this same procedure if you awaken in the middle of the night and are unable to return to sleep within about 10 minutes.

A common concern of many patients is that these procedures (not going to bed until they feel drowsy, getting up at the same time every day, and no naps) will result in their not getting enough sleep and being unable to function at work or school. It is important for therapists to reassure them that this is the best method for determining how much sleep a person needs to function well. Although it may result in less sleep in the beginning, eventually the body will adjust and get on a regular schedule. Patients may not function at their optimal level during this adjustment period, but they will be able to cope. They have probably been coping with fairly little sleep in the recent past, and this can be used as an example of how they will be able to get through this difficult time.

Goals for practice and recordkeeping should be arranged for each relevant behavior change. The timeframe for implementing these strategies should be determined by patients and therapists together.

Practice After reviewing the two handouts, therapists should reiterate the importance of following the sleep-hygiene and sleep-restriction and stimulus-control instructions every day.

Clinical Supervision

CRA + Vouchers should be supervised by a trained professional experienced in substance abuse treatment and behavior analysis. Supervisors provide significant input into treatment plans and all targets for behavior change. One of their primary functions is to keep the treatment focused on cocaine dependence and those problems that directly affect it, because this population presents with many additional problems that may have no direct relationship to cocaine use and can distract the therapist from the task at hand.

Supervisors' style should include a balance of support, feedback, problemsolving, and instruction. They should promote team problemsolving while also making clear that therapists have primary clinical responsibility for their patients' care. Considering that CRA + Vouchers requires an active therapeutic approach that can be effortful, the supervisor must serve as a stable source of support, encouragement, and direction in implementing the treatment plan.

Example of Supervision: Maintaining Focus

In a recent case, one patient's goal was to arrange for direct deposit of his paycheck so he would not have cash on hand to purchase cocaine. The paycheck clearly functioned as a cue for cocaine use. The patient agreed to the goal, and it became a top priority. The next week the supervisor asked if direct deposit had been arranged, and the therapist reported that it had not. The therapist also reported that the patient had received a paycheck and engaged in a cocaine binge. When the situation was discussed the goal with the patient who "agreed" to follow through; he did not and instead used cocaine. Records clearly showed that the patient had a poor history of following through on therapeutic goals and tasks. The supervisor acknowledged that he should have made it clear that they could not rely on the patient to make all the arrangements for direct deposit. Because it was important to maintaining abstinence , the therapist should have assumed partial responsibility for directly assisting the patient and closely monitoring whether the task was completed prior to any opportunity for cocaine use. In hindsight, the supervisor recognized his mistake in not clarifying the need to the therapist of ensuring that the task was completed. During the next session, the therapist accompanied the patient to the bank and helped make the necessary arrangements for direct deposit of the patient's pay check.

Weekly Clinical Staff Supervision

Weekly group supervision sessions are an efficient way to review cases. These meetings generally last about 2 - 3 hours and cover all new and active cases. During the meeting, therapists update the team on each patient's progress. Specific behavioral targets and goals are set. Supervisors assist therapists in evaluating progress and in revising plans that are not progressing adequately. The supervisor completes the Supervisor's Checklist (exhibit 36) for each patient each week to ensure that progress on all specific treatment goals is reviewed.

New Cases

New cases are presented according to the following guidelines.

- Cases should be staffed in the weekly supervision meetings within 1 week of case assignment.
- It is the therapist's responsibility to see that the following materials are available for the staffing:
- An overview of the intake notes, including a detailed lifetime history of cocaine and other drug use and the reasons the person is now seek ing treatment
- Other *relevant* historic or current situation information, such as prior treatment, probation status, other ongoing treatment, and suicidal ide ation
- Scores from the self-tests and assessment instruments used
- A completed problem list
- A tentative treatment plan

Treatment plans should be finalized after the therapist presents the new case and the supervisor and other staff have provided input. If more information is needed, the treatment plan can be finalized during the next supervision meeting.

- Goals and priorities should be set by the supervisor and therapist in col laboration. Both primary and secondary areas for change should be identified and prioritized. How and whether to use a voucher system should be decided.
- Goals should be operationalized. The supervisor should assist the therapist in defining goals in concrete, measurable terms so that progress on specific behaviors can be tracked.
- The supervisor should assist the therapist in determining how to mea sure and depict progress graphically in each goal area.

Exhibit 36: Supervisor Checklist by Case

Name_____ Dates	_____	_____	_____	_____	_____	_____	_____
Primary drug (graph)	_____	_____	_____	_____	_____	_____	_____
Secondary drug (graph)	_____	_____	_____	_____	_____	_____	_____
Attendance (graph)	_____	_____	_____	_____	_____	_____	_____
Primary behavior (graph)	_____	_____	_____	_____	_____	_____	_____
Secondary behavior (graph)	_____	_____	_____	_____	_____	_____	_____
Crisis?	_____	_____	_____	_____	_____	_____	_____
Name_____ Dates	_____	_____	_____	_____	_____	_____	_____
Primary drug (graph)	_____	_____	_____	_____	_____	_____	_____
Secondary drug (graph)	_____	_____	_____	_____	_____	_____	_____
Attendance (graph)	_____	_____	_____	_____	_____	_____	_____
Primary behavior (graph)	_____	_____	_____	_____	_____	_____	_____
Secondary behavior (graph)	_____	_____	_____	_____	_____	_____	_____
Crisis?	_____	_____	_____	_____	_____	_____	_____
Name_____ Dates	_____	_____	_____	_____	_____	_____	_____
Primary drug (graph)	_____	_____	_____	_____	_____	_____	_____
Secondary drug (graph)	_____	_____	_____	_____	_____	_____	_____
Attendance (graph)	_____	_____	_____	_____	_____	_____	_____
Primary behavior (graph)	_____	_____	_____	_____	_____	_____	_____
Secondary behavior (graph)	_____	_____	_____	_____	_____	_____	_____
Crisis?	_____	_____	_____	_____	_____	_____	_____

Active Cases

Therapists should present each active case, following the format outlined on the supervisor's checklist.

- The therapist should begin by presenting the patient's cocaine uri nalysis graph; this underscores the primary focus of treatment. Any recent cocaine positives should be discussed. Procedures to decrease the likelihood of further cocaine use should be suggested and spe cific behavioral interventions defined.
- Any alcohol or other drug use that is being actively targeted or moni tored should be reviewed. Graphs should be shown with urinalysis, breath alcohol levels, or self-report data, and interventions in that area should be reviewed or suggested.
- Any attendance problems should be discussed.
- The primary behavior change targeted, other than drug abstinence, should be reviewed and progress evaluated in graphic form. Any change in goals or new behavioral strategies should be suggested and implemented at this time.
- Up to four other secondary behavior change goals should be reviewed in a similar manner. Any change in goals or new behavioral strate gies should be suggested and implemented at this time.
- Once treatment targets are reviewed, any recent crises or relevant clinical issues, such as suicidal ideation or newly identified problem behaviors, should be discussed.

At any point in treatment, treatment goals and behavioral targets can be changed. Changes in goals may be precipitated by -

- Achievement of prior goals.
- Failure to make any progress toward a specific goal.
- Clear indication that the goal is not functionally related to cocaine use. Proposed changes should be discussed and specific revi-sions documented. This process should continue throughout treatment.

Counselor Treatment Team Meetings

Therapists and other staff members should meet daily to briefly (e.g., 10 minutes) inform each other about issues that may require team assistance. CRA + Vouchers requires a team effort, and CTT meetings are used to facili-tate and coordinate that approach. Therapists and other clinic staff can enlist one another's help to facilitate patients' behavior change by using their joint resources.

These meetings help keep therapists focused on patients' specific behavior changes and provide a means for group support, problemsolving, and accessing help from colleagues. Additionally, they serve as a prompt for therapists to be proactive in facilitating progress on their patients' goals. CTTs are particularly useful in facilitating continuity of care when therapists are out ill, on vacation, or otherwise unavailable. For example, if a goal of one patient is to complete an application for employment at a particular worksite but his therapist is not available to assist him, another therapist or staff member can volunteer to cover the case and assist in completing the application. Most importantly, CTTs enhance the clinic's ability to provide comprehensive and timely treatment interventions, which are the mainstay of the CRA + Vouchers approach to treating cocaine dependence.

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Appendix A: A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (CRA+V-2) Module 2

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

1. CRA+Vouchers teaches patients _____ interrelated ways to stop using cocaine.
   a. six
   b. five
   c. four
   d. three
   e. two

2. It is common tor persons trying to stop cocaine use to have _____ .
   a. skips
   b. blips
   c. slips
   d. crashes
   e. para-normal experiences

3. Therapists should go over the _____ components of functional analysis.
   a. six
   b. five
   c. four
   d. three
   e. two

4. A trigger is an event that occurs _____ a person uses cocaine and _____ the likelihood of using.
   a. after, decreases
   b. after. increases
   c. before, decreases
   d. while, delays
   e. before, increases

5. Which of the following feelings could lead to cocaine use?
   a. anxiety
   b. depression
   c. anger
   d. frustration
   e. all of the above

6. An easy way to identify cocaine-use patterns is to use a functional analysis _____ .
   a. map
   b. diagram
   c. script
   d. graph
   e. projection

7. Both the triggers and functional analysis forms cab be completed:
   a. as homework
   b. imaginatively
   c. subjectively
   d. in vivo
   e. as a dream analysis

8. The Self-management Planning Sheet can lead the patient through_____ steps.
   a. 5
   b. 6
   c. 9
   d. 8
   e. 7

9. The Self-management Planning sheet uses a difficulty scale of_____ .
   a. 1-20
   b. 1-50
   c. 1-100
   d. 1-10
   e. 1-5

10. The ability to refuse cocaine or other drugs when offered is a special case of _____ .
    a. denial
    b. intervention
    c. aggression
    d. confrontation
    e. assertiveness

11. There are _____ components of refusal responses.
    a. 7
    b. 6
    c. 5
    d. 4
    e. 3

12. Therapists help patients construct at least _____ typical scenes in which patients have had difficulty refusing cocaine.
    a. seven
    b. six
    c. five
    d. four
    e. three

13. Refusal practice includes:
    a. constructive feedback
    b. repeated role-play
    c. role reversal
    d. therapist modeling
    e. all of the above

14. Therapists should remind patients that the most important thing in developing effective refusal skills is:
    a. attitude
    b. practice
    c. a higher power
    d. willpower
    e. desire

15. The most commonly addressed skills-training components are problem solving, vocational satisfaction, social activities, social skills, and _____ management.
    a. personal
    b. personnel
    c. time
    d. social
    e. contract

16. Writing down appointments can:
    a. reduce stress
    b. avoid missed appointments
    c. increase awareness of accomplishments
    d. help organize plans
    e. all of the above

17. Therapists should introduce the _____ system of prioritizing.
    a. ABC
    b. XYZ
    c. AA
    d. SOS
    e. ASI

18. Daily lists should be an _____ exercise to reinforce _____ compliance.
    a. extra-session, between-session
    b. pre-session, post-session
    c. post-session, pre-session
    d. in-session, between-session
    e. between-session, in-session

19. Therapists and patients should attempt to categorize activities by interest, cost, time commitment, and whether it is physical or _____ .
    a. spiritual
    b. psychological
    c. sedentary
    d. neurological
    e. seditious

20. Therapists should encourage the use of _____ to pay for activities.
    a. contracts
    b. notes
    c. checks
    d. IOUs
    e. vouchers

21. There are _____ basic steps for problem solving.
    a. 7
    b. 6
    c. 5
    d. 4
    e. 3

22. Patients should consider:
    a. positive outcomes
    b. negative outcomes
    c. long-term consequences
    d. short-term consequences
    e. all of the above

23. Counselors providing a vocational component will benefit from the Job _____ Manual.
    a. Guide
    b. Club
    c. List
    d. Journey
    e. Vista

24. A specific, short-term attainable goal would be _____ job contacts per week.
    a. 7
    b. 6
    c. 5
    d. 4
    e. 3

25. The job counselor or therapist provides _____ vocational services to patients.
    a. 54
    b. 44
    c. 34
    d. 24
    e. 14

26. _____ training is appropriate for patients who tend to be either too passive or too aggressive.
    a. Self-control
    b. Self-esteem
    c. Anger management
    d. Centeredness
    e. Assertiveness

27. Learning and practicing assertiveness skills typically takes _____ sessions.
    a. two to four
    b. five to six
    c. six to eight
    d. eight to ten
    e. twenty

28. Try not to express feelings with _____ statements.
    a. I
    b. you
    c. we
    d. they
    e. it

29. More than _____ of the women with AIDS in the US are injection drug users or sexual partners of such users.
    a. one fourth
    b. one third
    c. half
    d. three quarters
    e. one tenth

30. HIV can be transmitted _____ ways.
    a. 6
    b. 5
    c. 4
    d. 3
    e. 2