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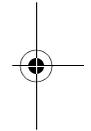
The Adolescent Community Reinforcement Approach and Multidimensional Family Therapy

Addressing Relapse During Treatment

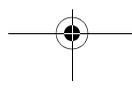
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Adolescent substance abuse treatments that involve family members and that seek to change or influence an adolescent's environment have demonstrated considerable efficacy in numerous randomized clinical trials (Austin et al. 2005; Dennis et al. 2004; Rigter et al. 2005; Vaughn and Howard 2008; Waldron and Turner 2008). Compared with standard care, these treatments have demonstrated superiority in enrolling and retaining youth in substance



abuse treatment, and in reducing not only drug use but also psychiatric comorbidity. A shared assumption among approaches is that adolescents are part of multiple systems, which are critical to incorporate as change agents or to address during treatment. In this chapter, we highlight two of these approaches, the adolescent community reinforcement approach (A-CRA) and multidimensional family therapy (MDFT), by presenting certain core interventions, practice guidelines, and principles of A-CRA and of MDFT in the context of case illustrations of how each approach addresses relapse during a treatment episode.

Few would deny that the prevention of relapse is an important goal of substance abuse treatment or that the probability of relapse or continued use among adolescents is extremely high (e.g., Brown et al. 2001; Dennis et al. 2004; Williams and Chang 2000; Latimer et al. 2000). Research has identified pretreatment, during-treatment, and posttreatment factors that may influence relapse, and although this research has been very illuminating, we argue that during-treatment factors have been unnecessarily narrow (i.e., length of treatment, extent of family involvement) and suggest that investigating how specific treatment approaches address relapse during treatment may offer insight into heretofore unidentified or underinvestigated factors. Family-based models and community reinforcement approaches generally, and MDFT and A-CRA in particular, acknowledge that relapse is an expected occurrence during adolescent substance abuse treatment, as well as an opportunity for growth and learning. Both A-CRA and MDFT delineate specific guidelines and procedures to address relapse that occurs during a treatment episode, and to prevent and minimize the harm of post-treatment relapse.

The Adolescent Community Reinforcement Approach

A-CRA is a behavioral intervention developed to treat adolescents with substance use disorders. It has been widely implemented through funding from the Center for Substance Abuse Treatment (Center for Substance Abuse Treatment 2006, 2009) and other sources in more than 50 treatment agencies in 20 states. Originally developed in the 1970s and 1980s as an approach to treat adults with alcohol disorders (Azrin 1976; Azrin et al. 1982; Hunt and Azrin 1973), the intervention was adapted for adolescents, manualized, and evalu-

ated as part of the Cannabis Youth Treatment study (Dennis et al. 2004; Godley et al. 2001). A-CRA also has been evaluated in randomized clinical trials of assertive continuing care (Godley et al. 2007) and as an intervention with homeless adolescents in the southwestern United States (Slesnick et al. 2007).

The overall style of A-CRA is behavioral or cognitive-behavioral. Therapists are trained to identify an adolescent's individual reinforcers and those of his or her caregivers. Once these reinforcers are identified, the therapist helps the adolescent and family draw the relationships between attaining reinforcers and reducing or stopping substance use. For example, an adolescent may want to "get off" probation or attend college. A parent may want his or her adolescent to get a good job one day or just stop "getting in trouble." These reinforcers can be used as therapists discuss with adolescents and parents why it is important to attend sessions, learn and practice new skills, and sample periods of not using substances. Another primary goal of A-CRA is to increase the family, social, and educational or vocational reinforcers of an adolescent, so that the adolescent's environment will increasingly support recovery. Conversely, if an adolescent uses alcohol or other drugs, then a time-out from these reinforcers occurs (based on Hunt and Azrin 1973). To facilitate engagement and retention, the therapist uses warmth, uses understanding statements, and is non-judgmental.

The A-CRA manual (Godley et al. 2006) developed for the Cannabis Youth Treatment study outlines an outpatient program that targets youth ages 12–18 years with cannabis, alcohol, and/or other substance use disorders, as diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision (American Psychiatric Association 2000). However, A-CRA also has been implemented in intensive outpatient and residential treatment settings (Godley et al. 2009). A-CRA includes guidelines for three types of sessions: adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together. Treatment begins with an overview of what the adolescent can expect and emphasizes that the goal of therapy is to help the adolescent have a more satisfying life.

Subsequent sessions are very flexible, and the clinician draws from a toolbox of 17 treatment procedures to help adolescents improve their quality of life and decrease or eliminate alcohol and/or drug use. Clinicians are taught to introduce each procedure with a rationale so the adolescent can understand how the techniques will be beneficial. One group of these procedures facili-

tates ongoing assessment and goal setting. For example, the Functional Analysis of Substance Use and the Functional Analysis of Prosocial Behaviors help the adolescent understand what patterns are associated with those behaviors and their positive and negative consequences. Then, the clinician and adolescent can discuss how these patterns might be changed. The Happiness Scale and the Goals of Counseling show that the therapist cares about the adolescents' happiness in important life areas and wants to help them achieve the goals they care about. Other procedures target skill building, including Problem Solving and Communication Skills to help adolescents learn how to address challenges and enhance their relationships. Because it is important for adolescents to engage in enjoyable activities without alcohol or drugs, there are procedures for increasing these activities, as well as a procedure called Systematic Encouragement to help the adolescent break down what will be needed to try out a new skill or activity and provide the adolescent the opportunity to try a first step during a therapy session. Some procedures, such as Anger Management and Job Seeking Skills, will be used only if needed by a particular adolescent. Two sessions are designed for caregivers alone, and two more are for caregivers and adolescents to work together on improving their relationship(s). These four sessions with caregivers are considered the minimum number; more can be added if needed. Role-playing/behavioral rehearsal is a critical component of the skills training components (e.g., Drug Refusal, Problem Solving).

Every session ends with a mutually agreed-upon homework assignment to either practice skills learned during sessions or engage in a new prosocial activity after potential barriers to completing the assignment are discussed and addressed through problem solving. To reinforce completion of homework, which helps ensure generalization of skills learned in sessions to the adolescent's natural environment, the clinician begins each session with a review of the homework assignment from the previous session.

Case Illustration

The following case illustrates how an A-CRA therapist would work with a youth who has had a relapse. Most A-CRA sessions are with the adolescent alone, and it is most often in this context that the therapist recognizes that an adolescent has had a relapse. Parents or others may ultimately play an important role in the relapse prevention plan, as described below. The clinician follows a

Table 10–1. Therapist guidelines for adolescent community reinforcement approach (A-CRA) sessions

1. The A-CRA clinician is positive, enthusiastic, and nonjudgmental during interactions with adolescents and caregivers. At the same time, the clinician provides guidelines and direction during sessions.
 2. The clinician consistently identifies the adolescent's and caregivers' reinforcers and helps them see how changes in their behavior can help attain these reinforcers. A behavioral approach is based on the premise that reinforcers will, by definition, be potent motivators for change. A prime example of this is A-CRA's emphasis on a satisfying but healthy social and recreational life to replace activities that have been dominated by substance use.
 3. The clinician understands the importance of checking for generalization of newly learned behaviors in the adolescent's and caregivers' lives outside of the session. This is why A-CRA clinicians work with the adolescent and caregivers to design homework assignments at the end of each session and check back regarding homework completion during each session.
 4. Procedures are introduced at clinically meaningful times for the most impact. Clinicians are expected to "weave" procedures into the session based on the adolescent's needs, rather than awkwardly announcing, "Today, we are going to do such and such procedure." Appropriate introduction of procedures translates into their having more meaning for the participant and greater generalization to real-world applications.
 5. Caregivers and other individuals who are important in the adolescent's life are involved in sessions or as part of case management activities. These individuals can help create either a positive and supportive environment for the adolescent or one that is negative and punishing. The A-CRA caregiver procedures are designed to increase the positive nature of these relationships.
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number of guidelines (see Table 10–1) during a session, regardless of the session content, and many of these are illustrated in the sample session dialogue that follows.

The youth in this case example, Tom, is 15 years old. He lives with his mother and sister. His drug of choice is marijuana, and he has struggled in school and been referred for treatment by the juvenile justice authority. Before the session described below, the therapist met with Tom several times. They have already completed a Functional Analysis (of Substance Use and Prosocial Behaviors) and the Happiness Scale, worked together on Goals of Counseling, and learned and

practiced communication and problem-solving skills. The therapist also has had two sessions with Tom's mother, during which the therapist described the A-CRA intervention, provided her the opportunity to talk about what she wanted for her son and her frustrations related to her son's behaviors, and reviewed important parenting skills (with an emphasis on what Tom's mother was already doing well). Prior to the session described below, Tom provided a urine test, and it was positive for marijuana.

First Session

THERAPIST: I'm really glad that you came to your session today. You knew there was a possibility that we would do a drug screen, and I'm guessing you also knew how it would turn out, so I think it is really good that this didn't keep you from coming.

TOM: Yeah. I had a relapse.

THERAPIST: What do you think about us talking about that—you know, looking at what happened, and thinking of ways you can avoid future relapses? Are you okay with that?

TOM: Yeah.

THERAPIST: Let's talk about what happened. I'll fill in another road map [Functional Analysis], and we can see if it adds anything to the one we did during your first session.

TOM: There's not much to say. My girlfriend broke up with me. On my way home, J.T. was feeling sorry for me and offered me some weed. When I got home, I smoked it.

THERAPIST: Gee, I'm really sorry about your girlfriend—that's really tough. We can definitely talk more about that if you'd like to. If it's OK with you, I'd like to just stick with the relapse for a minute though. You said J.T. was feeling sorry for you. What were you doing or saying that made him feel sorry for you? Looking at your prior road map, you said that your internal triggers were feeling sad and lonely. Do you think he was responding to that?

TOM: I guess so. I was pretty mad too.

THERAPIST: I understand. That makes sense. So I'm listing all of these feelings in the Internal Triggers column on your new road map [see Column 2 of Figure 10–1]. Do you remember why we try to identify internal triggers?

TOM: So I don't keep smoking every time I feel upset.

THERAPIST: That's correct. You were definitely right on target a few weeks ago when you said that feeling sad and lonely could lead you to a relapse. And here's some new information you've just come up with: feeling mad can set you up to smoke too. So we have to help you figure out a way to

do something different the next time you feel sad, lonely, or mad—so that you have more options to start feeling better besides smoking.

TOM: I could use more options. I can't keep getting in trouble.

THERAPIST: Before we figure out options, let's make sure we have the whole picture of what was going on when you decided to get high. Let's look at the external triggers now [Column 1 of Figure 10–1]. Like you told me before, you smoke alone at home after school. Now you mentioned that J.T. gave you the weed.

TOM: Yes. And I even told him that I'd better not. But when he kept pushing it my way, I just took it. I'm not saying it's his fault though. He didn't force me to smoke.

THERAPIST: He didn't force you to smoke, but he made it *easier* for you to smoke. It will be important for us to practice some drug refusal skills before we're done today. These are assertiveness skills that focus on ways to turn down offers of drugs from friends.

I've already listed the using behavior [Column 3 of Figure 10–1]. Let's go over the positive consequences of your smoking in this specific situation [Column 4 in Figure 10–1]. When we did your first road map, you said that some of the things you liked about getting high were feeling relaxed and mellow. Do these fit here?

TOM: Yes. But I especially like what I *don't* feel—or think—when I'm high: I don't think about or feel much of anything, which is *exactly* what I wanted. I didn't want to be thinking about my girlfriend.

THERAPIST: OK. And when you aren't having any unpleasant thoughts or feelings, are you having any positive feelings that you can identify? Think back to when you were physically feeling relaxed and mellow in that situation. What were some positive feelings?

TOM: Maybe I was feeling... I don't know... content? Not sure I'd say happy.

THERAPIST: I'll put "happy" with a question mark then. And I bet you can tell me *why* we're looking at the positive things you associate with smoking weed. Do you remember why we spend time on this?

TOM: I think you said it has something to do with why I get high in the first place.

THERAPIST: Good! We figure that you keep choosing to smoke in these situations because it gives you a number of positive things, like it helps you feel relaxed and content, and you don't have to think about unpleasant things. And so what do we need to do?

TOM: I need to not smoke.

THERAPIST: Yes, I'm hoping you continue to think that way. But it seems like we'd better come up with a plan so that you can get some of these positive things the next time you're sad or mad—but without your having to smoke.

External triggers	Internal triggers	Using behavior
<p>1. Who were you with when you used? <i>Nobody—but had just seen JT</i></p>	<p>1. What were you thinking about right before you used? <i>Was thinking all sorts of things—like why my girlfriend broke up with me</i></p>	<p>1. What did you use? <i>Marijuana</i></p>
<p>2. Where did you use? <i>Home—bedroom</i></p>	<p>2. What were you feeling physically right before you used? <i>Don't know</i></p>	<p>2. How much did you use? <i>1 small blunt</i></p>
<p>3. When did you use? <i>After school</i></p>	<p>3. What were you feeling emotionally right before you used? <i>Mad, sad, lonely</i></p>	<p>3. Over how long a period of time did you use? <i>1 hour</i></p>

Short-term positive consequences	Long-term negative consequences
<p>1. What did you like about using with (<i>nobody</i>)? <i>Nobody bothered me</i></p>	<p>1. What are the negative results of your using in each of these areas?</p>
<p>2. What did you like about using (<i>in bedroom</i>)? <i>Wouldn't get caught</i></p>	<p>a. Interpersonal <i>Mom will be really upset; a little mad at JT for giving me marijuana (he knows I've gotten in trouble for it already)</i></p>
<p>3. What did you like about using (<i>after school</i>)? <i>I needed to do something then because I was upset and I knew my mom was at work</i></p>	<p>b. Physical <i>Nothing</i></p>
<p>4. What were the pleasant <i>thoughts</i> you had while using? <i>I wasn't thinking much of anything, which is exactly what I wanted; I wasn't thinking about my girlfriend</i></p>	<p>c. Emotional <i>Problem didn't go away—I still feel upset, and now I'm mad at myself for relapsing</i></p>
<p>5. What were the pleasant <i>physical feelings</i> you had while using? <i>Relaxed, mellow</i></p>	<p>d. Legal <i>Not sure—but it can't be good</i></p>
<p>6. What were the pleasant <i>emotions</i> you had while using? <i>Content, happy?</i></p>	<p>e. Job/School <i>Didn't study that night and so failed a test the next day</i></p>
	<p>f. Financial <i>None</i></p>
	<p>g. Other</p>

Figure 10-1. Adolescent community reinforcement approach (A-CRA) functional analysis for relapse.

TOM: Sounds good to me.

THERAPIST: I'm glad you're on board. Let me ask first, though, if you remember talking about the negative or the "not-so-good" consequences associated with smoking?

TOM: Yup. We can start again with my mom being upset with me. Oh, and I didn't study that night when I was high, so I failed a test the next day.

THERAPIST: I'm going to add these to your new road map [Column 5 of Figure 10–1].

The therapist then discusses additional negative consequences and works with Tom to develop a relapse prevention plan. Some refusal skills training is included. In this case, the therapist believes that Tom's mother could be a helpful part of this plan. The conversation resumes at this point in the session.

THERAPIST: Based on what we know from this new road map and the earlier one, it looks like we need to find some things for you to do when you get upset so that you don't have to smoke. We'll probably have to find some immediate thing you can do, but I am also wondering about all the time you spend alone in your room in the evenings. We have talked a little about this before, and about how being lonely might set you up to relapse.

TOM: That's why I liked talking to my girlfriend at night—I mean my ex-girlfriend.

THERAPIST: Yes, and it looks like that might have helped for a while. But let's do one thing at a time. First let's concentrate on what you can do the next time you feel really sad or mad about something. Let's narrow it down further and say you get upset by something that happens in school. And remember that you're going to run into a number of your external triggers right after school.

TOM: Like J.T.

THERAPIST: Yes. So as for J.T.—let's take some time and do that assertive exercise I mentioned before.

At this time, the therapist reviews A-CRA's Drink/Drug Refusal Skills. The fact that Tom spends a lot of time home alone is also addressed in this session, in part because that behavior appears to be a trigger for relapse, but also because A-CRA stresses the importance of a satisfying social life that does not revolve around drugs.

THERAPIST: OK. So that deals with one trigger, J.T. What about another trigger: going home alone to your room?

TOM: Well, sometimes I like to be home alone. And I don't smoke *every* time I'm home alone—or upset.

THERAPIST: I'm sure that's true. But it seems like we have to be extra careful right now. One option would be for you to go somewhere else when you're upset so that you're around people—nonusing people. What do you think about that?

TOM: I think I'd like to be able to go home after school! I don't want to feel like it isn't safe for me to go home just because I'm upset.

THERAPIST: Fair enough. So what would make it safe for you to go home even if you were upset?

TOM: I don't know. I guess maybe it helps for me to talk to someone. But I could call or text them and still be at home.

THERAPIST: OK. And who would be a good person to talk to or text when you're upset? Of course, it should be somebody who won't give you weed to feel better!

TOM: I'm not sure. I have a few friends who don't get high, but I wouldn't want to whine to them about being upset.

THERAPIST: What about talking to your mom?

TOM: But she's not home then. She's at work until 6:00.

THERAPIST: Have you ever called her at work for an emergency? Can she take just a few minutes to talk?

TOM: But this wouldn't exactly be an emergency. Or maybe it would be...

THERAPIST: Oh, I bet your mom would consider this an emergency. It wouldn't have to be a long conversation. Maybe you could just let her know that you're upset and need someone to talk to for a few minutes. You could clear this plan with her ahead of time. Would your mom be up for this?

TOM: I think she'd make time to talk if she knew it was important. She can be real calm with me when I'm upset about stuff at school, so she might actually be a good person to talk to.

THERAPIST: Sounds like your mom would help you feel relaxed. Do you think you'd end up feeling content? This is important, because remember that we're trying to allow you to have some of those same positive things that you get from smoking when you're upset—but *without* smoking.

TOM: If I give it a chance, I think it might help. It's worth a try.

THERAPIST: Excellent. Let's practice the conversation you might have with your mom over the phone when you are in a situation where you're at risk for smoking and nobody is around to talk to you. We can use the communication skills we've been practicing.

The therapist reviews the A-CRA Communication Skills and applies them in this situation. Role-plays are used, and feedback is given. A backup plan using A-CRA's Problem-Solving procedure would also be developed in the event that the mother is unavailable to speak during a high-risk time. Once the immediate high-risk triggers have been addressed, the issue of Tom's spending a lot of time home alone is raised again.

THERAPIST: Now we have a solid plan for those times when you're really upset. But I want to get back to this idea of your loneliness in general being a trigger for relapse. I recall that we talked a few sessions ago about your going to work out with your friend as a way to stay out of the house some. What else can you do? Remember that these kinds of activities can help you not think about using, distract you, and keep you busy. For now, how about we focus on some things you might want to do over the weekend?

The therapist and Tom spend time coming up with a specific plan for engaging in a pleasant activity with a friend. As with all assignments, obstacles that might interfere with executing the plan are identified and addressed. Next, the therapist raises the possibility of Tom's spending some time with his mother as well.

THERAPIST: You've come up with a great plan for a fun activity with a non-using friend. I support you 100% for that! I'm also thinking, though, that one of the goals you mentioned when we did the Goals of Counseling exercise last week was to spend time doing fun things with your mom like you used to. What do you think about that as an option for this weekend too? The activity with your friend is for Saturday night. What about the rest of the weekend?

TOM: I don't know if my mom would want to. It's been a long time since we've done anything fun together.

THERAPIST: I can understand why you might wonder. What do you think about asking her?

TOM: I guess I could ask. But I don't even know what I'd be asking her to do.

THERAPIST: Good point. We can either figure that out here and you can ask your mom if she's interested, or you can go home and discuss it with her. You could even do a Problem-Solving exercise with her; I taught her how to do that when she came in here by herself last week.

TOM: I think I should first ask her if she has time to do something, and if she even wants to. She might not want to if she finds out I relapsed. Any-

way, if she wants to do something, I think it might be good to do some problem solving with her to come up with an idea.

THERAPIST: So how do you want to handle the relapse news?

TOM: I figure she'll find out one way or another, so I'd rather just tell her.

THERAPIST: Let's practice what you'll say to her. We can rely on the communication skills you've learned. Go ahead and give it a try. How would you start the conversation about the relapse?

TOM: Well, I'd say, "Mom, I know you've gotten upset before when I've had a relapse. I need you to know that I'm in control—I'm taking care of it—but I need you to help me this weekend. Do you want to do something this weekend—if you have time?"

THERAPIST: That's great. You used many of the elements of the communication skills we've been practicing. You told her that you *understood* how she felt about your relapse, and you even *understood* that she might be busy this weekend. Excellent! You also took some *responsibility* for your difficulties. And I liked how you made a request for help. Can you think of a way to make that request a little more specific? You mentioned earlier that you might like to do some problem solving with her to come up with an idea. You could even suggest doing that so there isn't pressure to come up with a specific activity on the spot. Or you could suggest a few activities.

The therapist uses A-CRA's Communication Skills training to help Tom shape how he talks to his mother. The role-play is repeated several times, with praise and specific suggestions offered. In an effort to increase the likelihood that Tom will actually have the conversation with his mother, the therapist encourages Tom to make the call to the mother during the session (i.e., using A-CRA's Systematic Encouragement procedure).

THERAPIST: You're doing a great job here today. It shows how committed you are to your goal of not smoking anymore. I'd like to mention one more strategy that's been helpful to people in your situation: an *Early Warning System*. This is an agreement you would set up in advance with a friend or family member—an agreement that the person would help you anticipate high-risk situations and be available to you in the event that you find yourself in one.

The therapist works with Tom to get specific about who Tom could ask to be part of his Early Warning System and what that individual would do, and to determine alternative plans (e.g., calling the therapist) if this person could not be contacted. Then the therapist has Tom role-play asking the person to help.

Second Session

At the next session, the therapist asks whether Tom needed to call his mom as they had practiced, and how it went. They review if Tom did the pleasant activity with his friend and if he enlisted the person identified to be part of his Early Warning System. Within the A-CRA framework, checking on homework (which is often called something else) helps the therapist know if a young person is learning to generalize the skills that he or she is learning within the sessions and that lead to sustainable behavior change. The therapist understands that completing homework is challenging for most adolescents. To increase the probability of success, the therapist and adolescent thoroughly discuss and problem-solve around barriers that might get in the way. If the homework is not completed, the therapist and youth work collaboratively to design another attempt for the following week, again problem-solving regarding potential barriers.

In this case, the therapist worked with Tom and his mother for about another month. The therapist had one more individual session with the mother to help her learn communication and problem-solving skills, and then two sessions with Tom and his mother together, during which they practiced these skills and completed Adolescent-Caregiver Happiness Scales, so they could talk about how to make their relationship more satisfying. Tom greatly reduced his marijuana use and improved his school attendance, and both Tom and his mother reported that they got along better.

Multidimensional Family Therapy

MDFT is a family-based, comprehensive treatment system for adolescent drug abuse and related behavioral and emotional problems (Liddle et al. 1991). The model is widely recognized in the United States and abroad as an effective science-based treatment for adolescent substance use disorders and delinquency (e.g., Liddle et al. 2008, 2009; Rigter et al. 2005; Vaughn and Howard 2004; Waldron and Turner 2008). MDFT is theory driven, combining aspects of several theoretical frameworks (i.e., family systems theory, developmental psychology, and the risk and protective model of adolescent substance abuse). It incorporates key elements of effective adolescent drug treatment, including comprehensive assessment; an integrated treatment approach; family involvement; developmentally appropriate interventions; specialized engagement and

retention protocols; attention to qualifications of staff and their ongoing training; gender and cultural competence; and focus on a broad range of outcomes (Austin et al. 2005; Brannigan et al. 2004; Jackson-Gilfort et al. 2001; Liddle et al. 2006).

MDFT is both a tailored and a flexible treatment delivery system. Depending on the needs of the youth and family, MDFT can be conducted from one to three times per week over the course of 3–6 months, both in the home and in the clinic. Therapists work simultaneously in four interdependent treatment domains—adolescent, parent, family, and extrafamilial domains—each of which is addressed in three stages: Stage 1, build a foundation for change; Stage 2, facilitate individual and family change; and Stage 3, solidify changes and launch. At various points throughout treatment, therapists meet alone with the adolescent, alone with the parent(s), or conjointly with the adolescent and parent(s), depending on the treatment domain and specific problem being addressed.

In Stage 1, overall therapeutic goals are similar for both the adolescent and parent domains. For example, in Stage 1, goals for both the adolescent and parent are to develop a therapeutic alliance and enhance motivation to participate in treatment and to change their behaviors. In this stage, the therapist creates an environment in which both the youth and parents feel empowered, respected, understood, and esteemed. The primary goals of Stage 1 are to develop a strong therapeutic alliance with youth and parents, and to enhance in each the motivation to truthfully examine oneself and be willing to change one's behavior. Accomplishment of these goals set the foundation for Stage 2, where the emphasis is on behavioral and interactional change.

In Stage 2, the longest stage in MDFT, most of the action takes place, and there are distinctive goals for each of the four domains. In the *adolescent domain*, the therapist works collaboratively with the parents and youth to help the youth communicate effectively with parents and other adults; develop coping, emotion regulation, and problem-solving skills; improve social competence; and establish alternatives to substance use and delinquency. For the youth, in particular, the therapist helps him or her feel safe to reveal the truth about his or her life generally, and about substance use in particular, to his or her parents and the therapist. The therapist must be nonpunitive and nonmoralistic about drug use; help the parents control their anger and disappointment and move to a more sympathetic and problem-solving stance; and encourage

the youth to have positive goals (to dream and hope) for himself or herself, and then highlight for the youth the discrepancy between those goals (e.g., graduate from high school, go to college, get a good job, avoid going to jail, get his or her own apartment) and continued drug use. In the *parent domain*, MDFT focuses on increasing the parents' behavioral and emotional involvement with their teen and on improving parenting skills, especially monitoring their teen's activity, clarifying expectations, limit setting, and articulating both negative and positive consequences. Work within the *family domain* focuses on decreasing family conflict, deepening emotional attachments, and improving communication and problem-solving skills. The MDFT therapist helps youth and parents see substance use as a health and lifestyle problem (e.g., it can interfere with the youth's getting what he or she wants out of life). Drug tests are used in the treatment as a way to encourage open communication about substance use, and to avoid the debate about whether or not the youth is using. Within the *extrafamilial domain*, MDFT fosters family competency in interactions with social systems (e.g., school, juvenile justice, recreational). The MDFT treatment team typically includes a therapist assistant who, in a highly coordinated collaboration with the therapist, works with the family members in the context of important institutions that influence their lives. For example, the therapist assistant might help the parents find a more appropriate school placement for their teen; obtain needed economic assistance, such as food stamps and Medicaid; or procure mental health or substance abuse treatment services for themselves or other children in the family.

Stage 3 helps parents and teens strengthen their accomplishments in treatment to facilitate lasting change, create concrete plans addressing how each will respond to future problems (bumps in the road, such as relapse, family arguments, and disappointments), and reinforce strengths and competencies necessary for a successful launch from treatment.

Planning Sessions and Setting Goals

Session planning and preparation is an important objective for the MDFT therapist. On a weekly basis, the therapist reviews, and modifies if necessary, the overarching therapeutic goals for each case, and then the specific goals for the upcoming week. Once the goals are established, the therapist can determine the focus of the sessions for the week, including how many sessions to hold, location of the session (home, school, clinic), and the individuals who

should attend each session (e.g., parents, youth, parent and youth, whole family). Goals are articulated in clear behavioral terms: what the youth and parents will do or say both within the session and outside the session. Session goals designed to address relapse are presented in Table 10–2. As is typical in MDFT, the goals have a temporal sequence; the goals cover the four domains of MDFT intervention (youth, parent, family, and extrafamilial); and these goals are accomplished over two to three sessions.

Interventions Designed to Meet Therapeutic Goals of Relapse Sessions

In the sequence of sessions designed to address relapse, typically the MDFT therapist begins with the parents alone. This could be a whole session of 45–60 minutes or part of a session (approximately 20 minutes). The length of the session and whether it is a whole session or part of a multipart session are determined by the therapist, based on his or her understanding of what is needed to accomplish the articulated therapeutic goals. For instance, if the therapist believes, based on prior work with the family, that the parents have a tendency to react in a very harsh manner, or that their disappointment and anger about the relapse will be tremendously deep, the therapist might decide that he or she needs a whole session to help the parents address these issues fully. If, on the other hand, the therapist determines that he or she can help the parents deal with their disappointment and set the foundation for having a productive conversation with their teen more quickly, then the therapist might begin by having the first part of a 90-minute multipart session alone with the parents. In this situation, the therapist first works alone with the parents, and then brings the youth into the session for a family discussion. The therapist's knowledge about the family and the MDFT model guides clinical decision making.

In that first full- or partial-session intervention with the parents, the therapist encourages the parents to fully discuss the situation, expressing their thoughts and feelings about the relapse, including their frustration, disappointment, hopelessness, and anger. The therapist aims to end this session or part of a session with the parents understanding that relapse is part of the recovery process and to be ready to address the relapse in a therapeutic instead of a punitive way. After a youth's relapse, especially if it is not the first relapse or if it is a particularly long-lasting or severe relapse, the parents may feel hopeless and want to give

Table 10–2. Therapeutic goals for multidimensional family therapy sessions addressing relapse

1. Parents understand the naturalness (a “law of life”) that relapse is part of the recovery process (two steps forward and one step backward).
 2. Parents agree to address the relapse in a therapeutic instead of a punitive way. They agree that their objective is to help the youth recover from the relapse, and to set in motion action to prevent further relapses.
 3. The youth describes the relapse (e.g., how it came about, what happened, what he or she was thinking or feeling, whether he or she tried to stop or prevent it, what is going on with him or her now).
 4. Parents listen to the youth and encourage him or her to feel comfortable revealing this information to them. Parents express to the youth their thoughts and feelings about the relapse, and agree that this means everybody must work harder to figure out how to best prevent future relapse.
 5. The youth agrees with the idea that everybody (parents, youth, therapist, and perhaps other family members) must work harder or differently to help prevent relapse.
 6. The youth and parents agree on a behavioral plan to prevent relapse.
 7. The youth and parents have reduced feelings of failure, frustration, shame, guilt, and anger toward self and each other.
 8. The youth and parents will continue to conceive of the solution to their problems from a developmental–family perspective.
 9. The youth and parents recognize the seriousness of the situation, but also realize that this is not the end of the world, and feel confident that the new plan to prevent relapse will work.
 10. The youth and parents continue to talk openly about substance use, relapse, and recovery, and to implement the behavioral plan, including refining and changing components as needed to be successful.
 11. The youth and parents consider whether or not increasing the youth’s involvement in prosocial activities, such as employment, tutoring, volunteer work, or sports, might help to crowd out opportunities for drug use. The therapeutic team works to assist the youth and family to locate such activities.
-

up on their child and either send the child to residential treatment or, if the juvenile justice system is involved, let the court place the youth in a long-term commitment facility. The therapist's job is to sympathize with the parents' disappointment, frustration, hopelessness, and pain, as well as to help parents recommit to help their child through this outpatient treatment. Of course, if the therapist believes that the teen cannot stop using drugs on an outpatient basis because of repeated relapses and if the youth is using substances to the extent that his or her life is in danger, then the MDFT therapist will recommend residential treatment and work with the youth and family to facilitate such treatment. In the case illustration that follows, the therapist has determined that the prognosis for the youth in an outpatient setting is favorable.

Case Illustration

Session With Mother

The following is a transcript illustration of how an MDFT therapist works with a parent who is hopeless following multiple relapses on the part of her son. The youth, Alex, is 16 years old, has been using drugs (primarily marijuana) and alcohol since he was 12, and at the time of treatment was on probation for repeated criminal offenses. Prior to this session, the mother called the therapist to say that she wanted to stop treatment. Her plan was to speak to Alex's probation officer and request incarceration for Alex. On the telephone, the therapist sympathized with the mother's position but also asked her to come into the clinic for one last session. After some reluctance, the mother agreed to one last session.

At the beginning of the session, the mother expresses her frustration: "I recommend harsher punishment. I mean, I am his mother but I can only do so much with a 16-year-old boy. He's gonna do whatever the hell he wants to do... Well, just like anybody who has an addiction, they're not going to quit until they're ready to quit. Whatever addiction, you can't make someone quit."

The therapist starts by simultaneously recognizing the mother's pain and hopelessness, and the seriousness of her son's situation:

 THERAPIST: I see you feel hopeless. You've done a lot, I understand, and now you are thinking that you don't know what more you can do. I know. And I agree you have done a lot. You've been here in treatment. You've been in court and at meetings with his probation officer. You've

tried everything you can think of and beyond, and there were times when he was doing OK, but now we are here, and you think, What more can I do? I understand that, and I don't have the answer, but I know he is in a real dangerous situation, and now he is saying he doesn't care if he goes to prison.

MOTHER: Yeah.

While staying with the mother's hopelessness, the therapist highlights the seriousness of her son's situation.

THERAPIST: And that bothers me because it is a big deal, and he probably doesn't realize that we're talking about his whole life. I know kids who go to prison for 6 months, and then they do something wrong—and it's a setup for messing up—and then the 6 months turns into 9 months. Then they get released and are on probation, and they have to be angels on probation. Nobody can do it. I couldn't do it. So they mess up in some way, and it's a probation violation; then they're back in prison for a few months, and so on and so forth. Then they turn around, and they're 25 years old, and from 16 to 25 this has been their life—in and out of detention and probation. I'm not trying to be melodramatic but...

MOTHER: You're right, and he has been told that. A very, very good friend of mine from high school has been in and out of prison, and it started with a little pot. Alex knows this. And it's like, "Well, it ain't gonna happen to me. I'm not that stupid. I'm not going to get caught."

A little later in the session, the mother agrees with the therapist about the danger her son faces—drug addiction and incarceration. The therapist responds by highlighting the seriousness of the problem, offering a solution, and once again acknowledging the mother's feelings of emotional depletion.

THERAPIST: Yeah, but that's what he doesn't understand. I told you I've seen this I don't know how many times. And then they're crying, but then it's too late. But now it's *not* too late. He can, you can, we can stop that from happening. There will come a point, though, when it will be too late, and then he'll cry, but then it's done.... The only thing I can think of goes back to you: that you are really the only one who can save him. Maybe a new or a renewed commitment from you will help. I'm thinking that is what needs to happen now. But I know you have so much on your plate, and I know what I am suggesting is not easy, and you've tried a lot and you feel like you've done a lot already, don't know how much more you have to give.... But...

MOTHER: This is my son.

THERAPIST: Exactly.

MOTHER: I mean, do I use tough love, do I become a little Hitler, or do I just smother him with kindness and love?

THERAPIST: Well, that's what we are here to figure out. But I do think, I mean, it's the only option: you're the mother, you're the parent. You are the only one who has influence on him. And when you start to give up, he will really give up. Look, I completely understand your feeling of wanting to give up. I know, because you've tried everything. And that's why it is so hard to be a parent, because you want to give up, you're tired, you've tried and tried, but you can't give up because there is nobody else.

MOTHER: So what do I do? There's like a thousand things going through my mind.

The MDT therapist does not want to go to problem solving too quickly. In this situation, the therapist decides not to do any problem solving in the session, and instead to spend more time alone with the mother, allowing her to fully explore the issues at hand—the mother's feelings of emotional depletion (“can't do this anymore”) and her son's jeopardy—and ultimately resurrecting the mother's commitment to keep working in treatment to help her son. To go to problem solving too quickly runs the risk that the mother's commitment will be only fleeting or inconsistently manifested, and of course, a commitment and solid foundation are necessary for the remainder of the therapeutic work.

The therapist stays with the topic of the mother's hopelessness, and offers the mother total support and understanding.

THERAPIST: I know you've done a lot. You told me about the problems in your marriage, and I know how draining that is. It's very hard to give as much as you need to give to your kids when you're in the middle of all of this relationship stuff. And you have a child who is in trouble, who needs even more. Right? So that's doubly hard. I don't know, I thought I heard you say at the beginning of the session that you don't have enough energy. That you can't dig down and find the energy that is needed to give to Alex now. What do you think?

MOTHER: Probably.

THERAPIST: That you do or you don't?

MOTHER: Remember that phrase I said to you a while back, that outward appearances are not inward reality? On the outside I'm happy and en-

ergetic, but on the inside I struggle....My mind is going 1,000 miles an hour, and I can't stop and focus on one thing because there are so many things that need to be attended to.

THERAPIST: But the thing is, you can't do everything. You're only one human being.

MOTHER: I think everybody thinks I'm supermom.

The session continues with the therapist sympathizing with the mother's burden, highlighting the seriousness of the situation for her son, and empowering the mother.

THERAPIST: I can see, as I said before, that you are a very smart person and you have a powerful personality. You can influence Alex. I know you can get him on the right track and then you'll look back and you'll say, "You know, I saved his life. I'm the one who did it. I made a difference. It was me." I can help, but it's really you. What you say here—the decision about putting your kids first, I mean—it's great. I really admire you for that.

At the very end of the session, Alex's mother stands up and looks the therapist directly in the eyes.

MOTHER: So when do you want to see him? If I have to go duct-tape his legs together and put him in the car, he will be here.

The therapist and parent agree to have a session as soon as possible with Alex, to hear from him and to begin developing a family-centered behavioral plan for how to help Alex stop using drugs and alcohol.

Session With Parent and Youth

The next core area of work is to facilitate an extended conversation between a youth and his or her parents, focusing specifically on what happened and why, and allowing the youth and parents to explore their feelings and thoughts about the relapse. The therapist needs to facilitate a focused discussion between the youth and parents in which the teen has sufficient time to fully voice his or her experience to the parents, and in which the parents listen and express themselves but at the same time refrain from excessive criticism and judgment—actions that can serve to push their child further away from them. This discussion should end in an agreement between the youth and parents 1) that this re-

lapse is serious but not the end of the world, 2) that what matters is how the youth and parents deal with the relapse, and 3) that they have to work harder or differently to prevent further relapses. If it has not been done already, this is a good time to drug-test the youth. In MDFT, the drug test is used not to catch or punish the youth but to encourage open communication between parents and child about the youth's use. Positive urine screens are defined not as evidence of the teen's addiction but instead as proof that continued and perhaps increased effort on everyone's part is required.

In the case of Alex, the next session, which involved Alex and his mother, occurred 2 days after the therapist's session with the mother. The therapist started the session by asking the mother to talk to Alex about some of the things that the therapist and the mother had discussed in the previous session, specifically the mother's decision not to give up on her son and not to let him give up on himself. The son was moved by the mother's strong commitment to not let him ruin his life. He cried and talked about his own struggles and disappointment in himself, and his desire to just go to jail to serve his sentence because he felt staying clean was too difficult. He said, "I just want to go to jail and get it over with. I can't do it. . . I'm going to fail probation anyway. I can't stay clean. So why not just go to jail now? It will be easier." At the end of this sequence, the therapist asked both mother and son to verbally state their new commitment to see Alex clean from drugs, back in school, and off probation.

The next part of the session was focused on problem solving, and Alex, his mother, and the therapist talked together about what they and others in the family could do to help Alex meet his goals. In MDFT, the family-centered behavioral plan is developed collaboratively and is conceived as just a beginning plan. It may work, but it may not work, and then the family and therapist will meet to revise the plan collaboratively. This prevents disappointment and extreme action (e.g., kicking the youth out of the house) if the plan does not work initially.

After this second relapse session, the therapist continued to work with the youth and family, addressing any problems and challenges they had in following their plan, adjusting the plan so it would work better for them, praising them for all their good work and accomplishments, and facilitating conversations about how much they love and appreciate each other. Alex was able to meet his goals of remaining drug free. He successfully completed probation and 2 years later graduated from high school.

Conclusion

The descriptions of the adolescent community reinforcement approach and multidimensional family therapy in this chapter reveal several ways in which they are similar, even though some of the underlying theories, therapeutic guidelines, and methods differ. (For more specific details about A-CRA and MDFT, see Godley et al. 2001 and Liddle et al. 2005, respectively.) Although A-CRA, MDFT, and other efficacious treatments for adolescent substance abuse have distinct therapeutic formats and methods, it has been suggested that carefully designed and implemented interventions will result in generally favorable outcomes regardless of specific therapeutic model, techniques, or methods (cf. Dennis et al. 2004). This view and the ensuing debate are not unlike the well-established debate in the broader field of psychotherapy, generally framed as follows: Do certain specific elements that are unique to different therapies make them more effective than others, or are the shared features across approaches responsible for treatment effects (DeRubeis et al. 2005; Norcross et al. 2006; Wampold et al. 1997)? It is possible that the similarities in certain therapeutic methods between A-CRA and MDFT illustrate certain important shared features.

Therapists implementing both approaches are highly nonpunitive and nonjudgmental toward youth and parents; in fact, this is one of the first instructions given to new therapists. In each approach, therapists are trained to 1) be aware of how their statements, in both content and tone, can be interpreted by youth and parents as judgmental; 2) desist from making such statements; and 3) pay attention to and comment on client strengths. Both approaches, then, are strength based, acknowledging strengths that are present, for example, in the existing parent-child relationship or in the adolescent's life. Both MDFT and A-CRA value the importance of therapeutic alliance and promote interactions between the therapist and the adolescents and caregivers that enhance this alliance. This focus on therapeutic alliance is consistent with the robust findings concerning the importance of therapeutic alliance to psychotherapeutic outcome across patient populations and treatments (see Horvath et al. 1993).

Although not evident in the clinical illustrations in this chapter, but as is well documented in other chapters in this book, comorbid disorders are very common among adolescents entering substance abuse treatment. Both A-

CRA and MDFT are behavioral interventions that do not exclude the use of pharmacotherapy when indicated. For clinicians who are not psychiatrists, both approaches have guidelines or procedures that can be helpful in working with disorders that co-occur with substance use. At a minimum, therapists are expected to screen youth for co-occurring problems and, when warranted, make appropriate referrals to a psychiatrist for evaluations and any indicated pharmacotherapy treatment and then work closely with the psychiatrist during subsequent treatment. For example, therapists can help support medication compliance and watch for medication side effects that can be reported to the psychiatrist.

Another commonality between these two approaches is that they are flexible and allow therapists to individualize processes or procedures. Qualitative interviews with therapists trained in these approaches have revealed that these attributes of MDFT and A-CRA are highly valued by therapists (Godley et al. 2001). In the case examples above, the specific content of the sessions was based on what was happening in the specific adolescent's or family's life, and both therapists helped the adolescents identify ways to replace substance use behavior specific to their interests. Both therapies acknowledge that plans or homework may not be completed as originally conceived, and require the therapist to work collaboratively with the youth and family to outline other plans or homework, while trying to discover and problem-solve barriers to success. Whereas the A-CRA therapist might talk about an individual youth's "reinforcers," and an MDFT therapist might talk about a youth's "hopes and dreams," these labels refer to the same constructs—that is, the importance of identifying what is individually meaningful for each youth.

Both approaches have sessions with the youth alone, with the parent(s) alone, and with the parent(s) and youth together. Although A-CRA may have more individual sessions with adolescents than does MDFT, and MDFT may have more family sessions, each approach recognizes that parents are critical in an adolescent's life. MDFT involves the family as a key agent of change, whereas A-CRA recognizes the family as crucial to creating a more positive environment for the adolescent, including one that is conducive to recovery. Likewise, both approaches recognize that other systems or parts of the adolescent's environment are also critical in facilitating recovery, including the school, peer group, other social services with which he or she might be involved, and even the work environment.

In this chapter, we have briefly described these two different adolescent treatment and family approaches. It is important to note that implementing these approaches with fidelity requires more than reading this chapter or the respective treatment manuals (see Godley et al., in press). Both approaches have been replicated often, and the development teams have learned that replication with fidelity takes much work from the trainers and developers, managers at replication sites, and therapists. A review of implementation research (Fixsen et al. 2005; Miller et al. 2006; Roman and Johnson 2002) reveals that this is true not only for these approaches, but for the now growing array of evidence-based approaches. A combination of training and ongoing support through coaching, expert reviews, and feedback on actual sessions is needed to ensure accurate implementation of the models. It is clear, however, that many adolescent substance abuse treatment therapists welcome evidence-based approaches that are individualized and flexible, that share a common language, and that focus on the strengths of adolescents and their families.

Key Clinical Concepts

Both A-CRA and MDFT share the following features, which perhaps form the outline of core features of efficacious adolescent substance abuse treatment generally:

- Relapse, an expected occurrence during adolescent substance abuse treatment, can be an opportunity for growth and learning if directly and systematically addressed in treatment.
- Therapists should be nonjudgmental and nonpunitive, and adopt a decidedly strength-based orientation to youth and families.
- Therapists should collaborate with youth to develop meaningful adolescent-driven goals.
- Family and other social systems are important to recovery.
- Manualized interventions should be both systematic and flexible, requiring therapist judgment, creativity, and clinical decision making.
- Successful implementation of evidence-based treatments requires therapists to participate in systematic and intensive training.

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