COMMON LANGUAGE for PSYCHOTHERAPY (clp) PROCEDURES
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COMMUNITY REINFORCEMENT APPROACH (CRA)

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Definition: In the community reinforcement approach (CRA) the therapist helps the patient to identify and engage in rewarding social and other activities in the community that compete with rewards from substance use, and persuades the patient to recruit a `significant other' to aid adoption of a healthier lifestyle.

Elements: The therapist trains patients' skills by role-playing with them how to refuse drugs and alcohol, communicate positively and appropriately assertively, and how to behave in job interviews, and encourages them to find and engage in pleasant hobbies and other non-substance related pursuits, and to enlist a trusted relative or friend for help in carrying out the CRA.

Application: Both individually and/or in groups and in different settings such as in- or outpatient settings, often supported by a relative or friend and combined with medication.

Related procedures: *Behavioral activation, contingency management, reinforcement, token economy, Morita therapy, motivational interviewing, nidotherapy, stimulus control, successive approximation; role play, social skills training; homework, diary keeping, problem-solving*

1st Use? Hunt GM, Azrin NH (1973)

References:

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2. Hunt GM, Azrin NH (1973) Community reinforcement approach to alcoholism. *Behaviour Research & Therapy*, 11: 91-104.
3. Meyers RJ, Smith JE (1995) *Clinical guide to alcohol treatment: Community Reinforcement Approach.* New York, NY, USA: Guilford Press.
4. Roozen HG, van den Brink W, Kerkhof AJFM (1997). Toepassing van naltrexon/clonidine bij een biopsychosociale behandeling (CRA) van opiaatafhankelijken. In Buisman WR, Casselman J, Noorlander EA, Schippers GM, de Zwart WM (Eds.). *Handboek Verslaving (B4250, 1-24)*. Houten: Bohn Stafleu Van Loghum (in Dutch).

Case Illustration (adapted from Roozen et al 1997)

Mary, aged 29, sought outpatient help to withdraw and then abstain from heroin especially and from cocaine and from methadone maintenance. A boyfriend had introduced her to drugs 9 years earlier. They broke up after a couple of years, after which she lived on her own. Recently she had stayed with her parents. She had been heroin-dependent for 8 years and on substitute methadone 40mg daily for 5 years. She

had had no meaningful job for some years and currently only had substance-using friends.

When the outpatient community reinforcement approach (CRA) began, Mary and her mother agreed with the therapist that mother would help Mary throughout treatment. Both attended weekly outpatient sessions over 6 months. Over 30 days Mary reduced cocaine and heroin use from daily to infrequently and took prescribed methadone more regularly; her methadone dose was increased slightly and stabilized. She then had opioid detoxification over 72 hours to stabilise abstinence from heroin and methadone. She had naltrexone (opioid-antagonist) induction followed by naltrexone 25mgs daily throughout the CRA to prevent relapse. After detoxification Mary felt depressed and spent most of her time in bed at her parents' home for three weeks, during which she reported one cocaine relapse. She completed happiness scales to evolve treatment goals with her therapist and mother. Mary targeted and was encouraged to do potentially rewarding activities such as: shop, visit family with mother, meet a non-drug-using old school friend, start fitness exercises and classes including stationary cycling (spinning) at a gym, and find a job. Mother helped Mary take her naltrexone and do homework assignments. Outpatient staff took urine specimens and did urinalysis. Mary, her mother and the therapist discussed and completed functional analysis forms showing that relief from depression was transient after substance use and alternative longer-term relaxation came from healthy pro-social behaviors, and Mary kept a `goals of counselling' diary. Completing the forms aided Mary's growing stimulus control by gradually avoiding drug-related situations and spending more time in pleasant activities, as above, incompatible with drug use. In rehearsals with mother and therapist in outpatients and at home visits Mary improved communication with mother. Mary also rehearsed job-interviews with her therapist. After 1-month abstinence verified by urinalyses, Mary found a nearby factory job and her mood improved rapidly. After 10 months of abstinence she discontinued naltrexone and the CRA, feeling confident she would stay abstinent. Mary kept her job, went on vacation with new friends, and engaged in frequent sports and other fitness activities such as spinning and jogging. She made new friends, and planned to start adult education classes to get a better job later. At 6 months follow-up she reported sustained abstinence.