EBTs for Families: "What Is CRAFT Again?"

Jeffrey Foote and Morton D. Rosenbaum
Center for Motivation and Change
New York, NY

For those tracking the evidence-practice gap, here's an update from the clinical front lines: whereas utilization of some Evidence-Based Treatments (EBT) is increasing, many effective treatments remain unknown and unused. One example of this is the options that are available for concerned significant others ("CSOs"—i.e., parents or partners) of substance users unwilling to enter treatment. Often a client will ask: "My husband won't stop drinking, and it's destroying our family. What should I do?" Even with decades of outcome research, this query continues to elicit the same two options: "You need to get to Al-Anon" or "It's time for an Intervention" (Fernandez, Begley, & Marlatt, 2006). A third option, Community Reinforcement and Family Training (CRAFT), although robustly supported by empirical evidence (e.g., Stanton, 2004), remains virtually unknown.

Anon Programs

A common response when a CSO is looking for help is to recommend Al-Anon (or other "Anon" programs), a 12-step support group where CSOs learn that they are "not responsible for," "can't control," and therefore should not attempt to impact their loved one's "disease" (Fernandez, Begley, & Marlatt, 2006). In Al-Anon, CSOs are encouraged to "detach with love" from the substance abuser, let the loved one "hit rock bottom," and accept that efforts to help are counterproductive (Stanton, 2004). However, some of these basic premises are not supported by evidence. For example, "hitting rock bottom" has not been demonstrated to be a critical mechanism of change (Carroll & Miller, 2006), whereas family involvement has been shown to be important for change (O'Farrell & Fals-Stewart, 2003). In fact, family influence is the most commonly cited reason for treatment entry among help-seeking substance users (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001). Anon involvement can provide useful support for self-care efforts; however, these programs do not aim to help the CSO engage the substance user into treatment. Thus, in controlled trials, engagement rates of substance users whose loved ones participate in Al-Anon are low and range from 0%-15% (Stanton, 2004).

Interventions

An increasingly prevalent recommendation for CSOs is the Johnson Intervention (JI). The JI involves a surprise confrontation of the "identified patient" (IP) by family, friends, and/or employers. CSOs recount difficulties experienced due to the IP's substance use, implore the IP to enter treatment, and outline negative consequences for non-compliance (e.g., divorce).

Since its conception nearly 40 years ago, JI has been the subject of three methodologically valid studies, with treatment engagement rates of 23% (Miller, Meyers, & Tonigan, 1999), 36% (Liepman, Nirenberg, & Begin, 1989), and 0% (Barber & Gilbertson, 1996). Many clinicians who perform interventions ("Interventionists") cite high engagement rates with no empirical data. Most studies that report high engagement rates are typically severely methodologically compromised and either exclude those families who refuse to follow through with the procedure (Logan, 1983) or use non-random, cross-sectional, retrospective samples (Loneck, Garrett, & Banks, 1996a; Loneck, Garrett, & Banks, 1996b).

Interestingly, in the three methodologically valid studies cited above, over two thirds of the families dropped out before the final stage (Stanton, 2004). JI is so confrontational that many families who complete the process may actually do more harm than good, laying the groundwork for a "predictable rebound in which those clients subjected to it are more likely to relapse than clients with whom less confrontational techniques are applied" (Garrett, Landau, Shea, Stanton, Baciewicz, & Brinkman-Sull, 1998, p. 334).

It should be noted that ARISE, a modified JI, has achieved substantially higher engagement rates. ARISE invites the substance user to be part of the process from the outset and follows a series of gradually intensifying stages, with only the third stage resembling traditional JI. In clinical trials, treatment engagement was achieved in 80% of cases before the family progressed to stage three, with only an additional 2% achieving treatment engagement at that point (Landau, Stanton, Brinkman-Sull, Ikle, McCormick, Garrett, et al., 2004).

Community Reinforcement and Family Training (CRAFT)

Since the early 1990's, a third option, CRAFT, was developed and researched in randomized controlled trials. CRAFT is a behavioral and motivational treatment for CSOs (Smith and Meyers, 2004) and is based on the empirically supported Community Reinforcement Approach (Meyers, Villanueva, & Smith, 2005). CRAFT has two goals: engaging the IP in treatment by providing behavioral training for the CSO, and enhancing CSO self-care. A primary strategy of CRAFT is to create a relationship environment where abstinence/change behaviors are positively and incrementally reinforced. CRAFT enlists CSOs as powerful collaborators in effecting change without the use of detachment or confrontation (Meyers, Miller, Hill, & Tonigan, 1999; Meyers, Miller, Smith, & Tonigan, 2002; Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007).

In several clinical trials, CRAFT engaged the IP into treatment with rates of 74% (Meyers, et al., 1999), 64% (Miller, Meyers, & Tonigan, 1999), 67% (Meyers, et al., 2002), 64% (Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999), and 71% (Waldron, et al., 2007). CSOs reported significant improvements in their own happiness, and also reported reduced anxiety and anger. IPs also significantly reduced substance use, regardless of whether they entered treatment.

Why CRAFT Is Rarely Practiced: The Philosophical Divide

Twenty years after its development, CRAFT remains nearly unheard of in the clinical world. As of this writing, we believe that there are between five and seven centers in the U.S. that currently provide CRAFT (Meyers, R. J., personal communication, September 30, 2009). We often receive out-of-state calls from parents or spouses who would like to participate in CRAFT but have no access to trained CRAFT providers in their area. Meanwhile, JI, demonstrably ineffective and often of great emotional cost, continues to capture public attention (see A&E channel, "Intervention") as a valid approach to encourage substance users to get treatment (Fernandez, Begley, & Marlatt, 2006).

There are many pragmatic obstacles to implementing EBTs, such as financial constraints and training difficulties (McLellan, 2006). We suggest an additional philosophical obstacle. The model of addiction that has shaped treatment in the United States – the "disease" model – is comprised of several tenets (Miller, 1993) that are at the core of approaches like Al-Anon and JI. One important tenet is that the "addict" suffers from "character defects" such as poor judgment and untrustworthiness. Indeed, surveyed addiction counselors endorse moral judgments like "alcoholics are liars and cannot be trusted" (Moyers & Miller, 1993).

Within such a framework, it seems that collaborative, respectful approaches that are not reliant on confrontation, detachment, or a basic stance of distrust may be viewed as suspect, whereas more dramatic approaches that do not grant basic trust and respect to substance abusers can flourish. The Anon and JI approaches differ significantly—one advocates for family detachment, one advocates for family confrontation—yet, they are both based on the premise that "addicts" cannot be collaboratively and respectfully engaged, leaving only the options of detachment and ultimatum.

Behavioral approaches like CRAFT, in contrast, work with broad psychological principles of learning, positive reinforcement and support, rather than treating the "addict" as a qualitatively different kind of patient for whom standard psychological processes do not apply. The distinction drawn between "addicts" and other patients can allow for clinical treatment that would not otherwise be tolerated. In his comprehensive outcome review of CSO-enlisting approaches, Stanton joins other concerned researchers to encourage reducing the practice of JI: "Too often I have seen people who were the target of the intervention describe the experience with tears welling up in their eyes. Years later, the humiliation and the pain of betrayal are still with them, still palpable" (2004, p. 177).

Clearly, neither families nor the professionals they consult are without compassion – all are dealing with fear, pain, confusion, and, at times, imminent danger. This discussion is intended to emphasize the importance of providing our clients with effective options and treatments that are based on evidence. In working with families, this would mean reserving JI for the rare cases in which it may seem necessary and presenting Anon groups to clients as a valuable source of support, but not as a path to engaging their loved ones in getting help. Powerful tools exist for helping our clients; utilizing these tools has remained a daunting challenge.

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