Therapist Reactions to Manual-Guided Therapies for the Treatment of Adolescent Marijuana Users

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Treatment researchers are increasingly advocating the use of evidenced-based treatment manuals. Here we describe therapist reactions to the use of manual-guided therapies in a multisite, randomized field experiment that evaluated five outpatient treatment protocols for adolescents who abuse or are dependent on marijuana. Data are summarized from qualitative interviews with 16 therapists and 3 case managers who provided the treatments. All of those interviewed felt that the manuals provided a structure to their therapeutic work, and the majority felt they were able to address individual patient needs. Therapists' reactions did vary depending on the type of manual they used (e.g., session-based, principle-based, or procedure-based). Recommendations for the development and use of manual-guided therapies to improve adolescent substance abuse treatment are discussed.

Key words: **treatment manuals, psychotherapy research, adolescent, substance abuse, clinical practice.** ***[Clin Psychol Sci Prac 8:405–417, 2001]***

Treatment manuals, which have been called a "small revolution" in psychotherapy research (Luborsky & DeRubeis, 1984), are one of many methods developed to improve the science of psychotherapy research. More recently, rising behavioral health care costs have increased the demand for evidenced-based practice (including manuals) to improve quality of care and needed guidance for practitioners (Addis, 1997; Strosahl, 1998). While some have advocated for manuals to help train clinical psychology doctoral students (Craighead & Craighead, 1998; Moras, 1993), others believe that master's degree therapists commonly found in practice settings would benefit even more than doctoral students from the use of manual-guided interventions (Strosahl, 1998; Wilson, 1996).

Concerns about the relationship of science and practice have also been raised in the substance-abuse treatment field. By the end of the nineteenth century, the perceived breach between knowledge and the then-prevalent methods of profit-motivated addiction cure institutes and purveyors of bottled cures for alcohol and drug habits led to calls to expand research and governmental regulation of addiction treatment enterprises (Crothers, 1891, 1893, 1900). Criticism of the poor scientific foundation for treatment approaches continued even after a national network of addiction treatment institutions arose in the 1960s and 1970s (Burglass & Shaffer, 1981; Kalb & Propper, 1979; White, 1998). Recent reviews of substance abuse treatment research have often concluded that the most successful interventions are not part of mainstream substance abuse clinical practice and that mainstream approaches lack scientific support (Lamb, Greenlick, & McCarty, 1998; Miller & Hester, 1986). Other studies have shown that when existing substance-abuse treatments are manualized and guided by the rigorous quality assurance standards common in research studies, they can be as effective or more effective than many of the research-based treatments (Crits-Christoph et al., 1999; Mercer & Woody, 1999). Influenced by developments in psychotherapy research, substance-abuse treatment researchers have begun advocating for and adopting methods (including manuals) to improve substance-abuse treatment research and practice (Carroll, 1997; Carroll, Kadden, Donovan, Zweben, & Rounsaville, 1994; Carroll & Nuro, 1996).

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In the general psychotherapy literature, more than 60 treatment manuals have been identified (Lambert, Chiles, Kesler, & Vermeersch, 1998), including manuals for treating sleep disorders, marital problems, borderline personality disorder, and substance abuse. The adult substance abuse treatment field now has many manuals providing descriptions of diverse treatments, including cognitive-behavior treatments (Kadden et al., 1992; Yost, Wakefield, Williams, & Patterson, 1992), community reinforcement approaches (Budney & Higgins, 1998; Meyers, Dominguez, & Smith, 1996; Meyers & Smith, 1995), motivational enhancement therapy (Miller, Zweben, DiClemente, & Rychtarik, 1995), 12-step facilitation therapy (Nowinski, Baker, & Carroll, 1992), and systemic treatment (Shoham, Rohrbaugh, & Steinglass, 1992). Published manual-based interventions specifically designed for substance-abusing adolescents are just beginning to emerge. Many are under development from the U.S. Center for Substance Abuse Treatment (CSAT)-funded projects (Dennis et al., in press; Stevens & Morral, in press) and the National Institutes on Alcoholism and Alcohol Abuse projects (Godley, Godley, & Dennis, 2001; Wagner, Brown, Monti, Meyers, & Waldron, 1999).

Critics of manual-based treatments have outlined a number of concerns regarding their use in applied practice settings. These include that manual-based treatments (a) do not allow for idiographic case formulation and therefore do not allow for individualization of treatment; (b) do not address the heterogeneity of treatment participants seen in the real world as compared to those included in clinical trials (e.g., comorbid problems will be ignored); and (c) will produce negative treatment effects because therapy will be conducted in a rigid, step-by-step fashion (Addis, 1997; Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997; Holloway & Neufeldt, 1995; Kendall, 1998; Silverman, 1996; Wilson, 1996, 1998).

A number of authors have posed rebuttals to the above concerns. Wilson (1996, 1998) has argued that an idiographic case formulation does not necessarily guarantee quality treatment. Under these principles, therapists can draw on hundreds of theories for a clinical formulation, and there is a high degree of clinical judgment involved. This could lead to subjective biases and/or the choice of a poor approach. Wilson (1996, 1997) also argues that manual-guided treatment does not necessarily preclude individualization of treatment, nor does using manuals preclude attention to comorbid problems. Kendall, Chu, Gifford, Hayes, and Nauta (1998) argued for a middle ground between the complete freedom of an unstructured treatment and the strict adherence to every detail of a treatment manual. They suggest that treatment manuals can be understood as general theoretical frameworks that provide guidelines and directions to therapists without restricting their clinical judgments.

In this article we explore some of the purported benefits and concerns associated with manual-guided therapy through the analysis of qualitative data from therapists using manuals in a randomized field study. There are only a few studies that provide data on this topic from therapists (Addis & Krasnow, 2000; Najavits, Weiss, Shaw, & Dierberger, 2000). Many investigators have advocated for the use of qualitative techniques for this type of study (Addis, 1997; Addis, Wade, & Hatgis, 1999). Therefore, data for this study were obtained by interviewing 19 therapists and case managers who provided manual-guided therapy in a large, randomized field experiment.

DESCRIPTION OF THE CANNABIS YOUTH TREATMENT STUDY

The Cannabis Youth Treatment (CYT) Study (Dennis et al., in press) was a multisite, randomized field experiment examining five outpatient treatment protocols for adolescents who abused or were dependent on marijuana. This was the largest field experiment of substance-abuse treatment ever conducted with adolescents. Organized as a cooperative agreement, the study was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and its CSAT under the U.S. Department of Health and Human Services. During the 4-year study (October 1997 to September 2001), a total of 600 adolescents were randomly assigned to 1 of 5 interventions across the 4 treatment sites in Connecticut, Florida, Illinois, and Pennsylvania.

Study Participants

To be included in the study, adolescents had to (a) be 12–18 years old, (b) endorse one or more *DSM-IV* (American Psychiatric Association, 1994) lifetime criteria for cannabis abuse or dependence, and (c) self-report marijuana use in the past 90 days. Exclusion criteria generally indicated the need for more intensive substance-abuse treatment (i.e., residential). To be excluded from the

study, adolescents had to (a) self-report alcohol use 45 or more days of the 90 days, (b) report use of other drugs besides marijuana 13 or more of past 90 days, (c) have an acute medical or psychological condition, (d) have a history of severe violent behavior, and (e) be non-English speaking.

The majority of the adolescents who participated in the study were male (83%), in school (87%), started using before the age of 15 (85%), white (61%), had a history of victimization (57%), were from single-parent households (50%), and were 15–17 years old (79%). Approximately 62% were involved in the criminal justice system at the time of their entry into the study, and 42% were under pressure from the criminal justice system to attend treatment. Seventy-one percent reported weekly use of marijuana, and 17% reported weekly use of alcohol. Most of the sample also had one or more co-occurring problems; these included conduct disorder (53%), attention-deficit hyperactivity disorder (38%), acute emotional (27%) or memory distress (27%), acute health problems (26%), and/or pregnancy among the females (11%).

Therapist Recruitment and Tenure

Therapists were recruited for the study in a number of ways. Sites advertised for applicants or invited already known therapists to apply. Selected applicants were then interviewed for specific interventions. During the interview, applicants were told that they would be working in a research study, a brief synopsis of the study, and a more detailed explanation of the intervention(s) for which they were being considered. They were also told that they would be expected to follow a manual and would receive close supervision. The investigators looked for individuals that either had experience or seemed compatible with the intervention they were being hired to provide and who were good clinicians. Two sites were located in substance-abuse agencies, and each recruited at least two therapists from their organizations. Approximately three-quarters of those hired had never used treatment manuals. Data are not available on the total number of therapists who applied for positions, but no therapist declined a job offer due to treatment manuals or the research context. Over the course of the study, 5 of 19 therapists and 3 of 6 case managers resigned. Reasons for resigning included the treatment site was too far from their homes ($n = 3$), a promotion or further education ($n = 3$), spouse relocation ($n = 1$), and personal reasons ($n = 1$). One counselor was asked to leave due to poor clinical skills. There were no indications that discomfit with the treatment manual led to any of these resignations.

The Five Interventions

CYT tested five specific types of outpatient treatments. The approaches varied by theoretical orientation (motivational, cognitive, behavioral, family systems), length (5 sessions vs. 12 sessions), mode (group, individual), and level of family involvement. The five interventions will be described in detail elsewhere, but brief descriptions of the interventions and the manuals are summarized below.

Motivational Enhancement Therapy/Cognitive Behavior Therapy 5 (MET/CBT5). MET/CBT5 (Sampl & Kadden, 2001) is composed of two sessions of MET and three CBT group skills-training sessions. MET is based on principles of cognitive therapy and the client-centered approach of Carl Rogers (Miller & Rollnick, 1991). In the CYT model, the therapist provides two individual sessions with the goal of helping clients resolve ambivalence and reach a commitment to change. The three group sessions that follow are designed to remediate deficits in skills for coping with antecedents to marijuana use, and some basic alternative skills are taught (refusal, social support and pleasant activities enhancement, handling emergencies, and relapse prevention) for coping with situations that might otherwise lead to marijuana use (Monti, Abrams, Kadden, & Cooney, 1989).

The MET/CBT5 manual might best be described as session based. The rationale for brief treatment, the basis for MET, and the rationales for CBT and group therapy are outlined. After five key strategies of MET are explained, the manual provides step-by-step explanations of what is to occur in each of the MET and CBT sessions. For each session there is a list of materials needed and a recommended breakdown for session activities.

Motivational Enhancement Therapy/Cognitive Behavior Therapy 12 (MET/CBT12). MET/CBT12 (Webb, Scudder, Kaminer, & Kadden, 2001) is a longer version of MET/CBT5 and is also a session-based manual. Therapists delivering this intervention use the MET/CBT5 treatment manual for the first five sessions and a different man-

ual for seven additional group sessions that provide the opportunity for more skills training and practice. The additional sessions address problem solving, anger awareness, anger management, communication skills, resistance to cravings, depression management, and management of thoughts about marijuana.

The Family Support Network (FSN). FSN (Hamilton, Brantley, Tims, Angelovich, & McDougall, 2001) adds to MET/CBT12 a family support component that includes six parent education groups, four in-home therapy sessions, and case management. FSN is based on research that suggests that the incorporation of family support in treatment increases retention and improves outcomes (Brown, Meyers, Mott, & Vik, 1994; Henggeler et al., 1991; Stanton & Shadish, 1997; Liddle & Dakof, 1995). The goal of the parent education component is to build competence among parents to lead healthy families, offer methods for coping with the pressures of parenting, promote ways to establish or restore appropriate authority, roles, rules, boundaries, communication and routines, and build competence in dealing with recovery issues through multifamily group education sessions. The goal of home visits is to assess the family environment, individualize the treatment process, develop family commitment to recovery, encourage a three-way therapeutic alliance (family, adolescent, and program), and translate lessons parents and adolescents are learning into specific changes in family functioning. The goal of the case management component is to help the families with problem solving and motivation through outreach.

FSN includes both the MET/CBT5 and MET/CBT12 manuals, as well as the FSN manual itself. In the CYT study, different components were delivered by different staff members. One therapist provided the MET/CBT12 intervention, family therapists provided parent education sessions and home visits, and case managers provided case management. The FSN manual describes the six parent education groups, the four home visits, and case management procedures. The parent education portion of the manual provides a session-based curriculum for each group meeting. The home visit portion of the manual is also session-based in that a prescribed set of goals are to be addressed in each visit. The case management portion is less structured and outlines a number of goals, procedures, and the guiding model. It does not prescribe what should occur in each session. Case managers are expected to adjust the intensity and content of the case management depending on individual needs.

Adolescent Community Reinforcement Approach (ACRA). ACRA (Godley et al., 2001) is an individualized behavioral approach that includes 10 sessions with the adolescent and 4 sessions with caregivers. This approach, which has proven effective for adults (Azrin, Sisson, Meyers, & Godley, 1982; Meyers & Smith, 1995; Smith, Meyers, & Delaney, 1998), is based on the premise that learning alternative skills to cope with problems and changing environmental contingencies related to continued substance use can help reduce use. Its goals are to change antecedent behaviors of the adolescent and increase behaviors by parents that support abstinence. Core adolescent procedures include (a) a functional analysis of substance use, (b) a functional analysis of prosocial behaviors, (c) a happiness scale (modified to reflect areas important to adolescents) and ACRA treatment plan, and (d) additional skill-building procedures. Core caregiver procedures include (a) an overview of ACRA, rapport building, and motivation, (b) communication skills training, and, (c) review and practice of relationship skills with the adolescent participants.

The ACRA manual is best described as procedure based. After an explanation of the underlying model, the manual describes in detail how to deliver the 12 core and 3 optional procedures. The manual provides a suggested sequencing of procedures by session, but the therapist has the freedom to select procedures to address what the adolescent and/or caregiver presents during the session. Real-life experiences are used to illustrate procedures, and adolescents and caregivers are asked to practice techniques in between sessions.

Multidimensional Family Therapy (MDFT). MDFT (Liddle, 2001) is composed of 12–15 individual and family sessions and additional meetings as needed with extrafamilial others at school, in the juvenile justice system, or related to job training. MDFT is a family-based, developmental-ecological, multiple systems approach to treating adolescent substance abuse which grew out of Structural Family Therapy (Minuchin, 1974). It uses developmental psychology and developmental psychopathology to inform the clinician's treatment focus and goals (e.g., parenting practices, autonomy and attachment, cognitive development). The treatment targets the functioning of

multiple systems and their interrelationships—the adolescent, parent, family interactional patterns, and other social systems that can impact the adolescent. The initial phase of treatment emphasizes a multisystemic assessment, establishing therapeutic alliances with all family members, definition of treatment goals, and facilitating motivation and engagement of family members. The mid-phase focuses on working the identified clinical themes, and the final phase focuses on generalization and maintenance of change.

The MDFT manual might best be described as principle based, and it provides an extensive description of its underlying theoretical model. Liddle (2001) explains that therapists must understand a framework that is complex and multivariate in order to know how to respond to clinical phenomena presented. The manual describes how the principles of MDFT are used within CYT to address four modules (adolescent, parent, and other family members, and extrafamilial systems) and three stages of treatment within the CYT 12-week period. Following theoretical explications of the model, case examples and transcripts of actual sessions are used to illustrate the intervention.

CYT STUDY TREATMENT QUALITY CONTROL PROCEDURES

A number of procedures were put in place to ensure that the therapist adhered to the manual and delivered the treatment in a competent manner. Each treatment condition was overseen by a work group that included an expert in the approach (typically the developer) and a therapist coordinator responsible for day-to-day implementation across sites. All therapists attended at least one centralized 2-day training workshop focusing on the principles and techniques of their respective treatment. Therapist coordinators conducted on-going quality assurance by reviewing all therapy sessions (via audio or videotape) until each therapist was certified by the therapist coordinator and the treatment expert. After certification, two tapes per therapist per month were reviewed to assure ongoing adherence to the model.

USE OF MANUALS

The manuals were used during staff training, delivery of the intervention, and clinical supervision. All therapists and case managers were required to read their manual before participating in a 2-day training. The manuals provided a common theoretical background and language for each intervention and served as a reference during clinical supervision sessions. The type of intervention dictated how often and why therapists consulted their manuals. Those using session-based manuals (MET/CBT, FSN) typically reviewed their manual before each session to assure that they were covering the material outlined for that session and to review exercises and homework plans for that session. Therapists delivering ACRA reviewed their manuals before sessions to familiarize themselves with the steps of a procedure as outlined in the manual. MDFT therapists primarily used their manuals to help generate ideas for a session and to help structure the direction of the therapy. Most of the manuals had post-session measures or checklists related to the session or procedure that therapists were instructed to complete, and these helped them identify what they had done well in the session and were used in supervision.

METHODS

Procedure

Interviews. The qualitative data for this study were collected with semistructured interview questionnaires. Therapist and case manager interviews began with 23 open-ended questions in two major areas: their experiences using the manual and the importance of various supports for using the manual (e.g., training, supervision). Clinical staff were also asked about their tenure on the project. As appropriate, open-ended questions were followed by probes.

Each respondent was interviewed by telephone for about 1 hr and asked questions about a specific CYT manual (some therapists provided more than one intervention). Each interview was conducted by a trained interviewer who was not involved in the clinical trial. Most interviews were conducted over a 2-month period near the final treatment phase of the study. Audio tapes of the interviews (or interview notes, since five interviews had taping problems) were later transcribed to be used with computer software designed for use with qualitative data.

Therapists Interviewed. A total of 25 interviews were conducted with 16 therapists and 3 case managers (76% of the total who participated in the study at any time). Six of the therapists delivered two of the interventions and were interviewed regarding each of the interventions they delivered. At the time of the interviews, the amount of time therapists had worked on the study ranged from 1 to

18 months. Almost half of the therapists (9) had worked on the project for 17 or 18 months, 5 had worked on the project between 12 and 18 months, 2 had worked between 6 and 12 months, and 3 therapists had worked on the project fewer than 6 months. There was considerable variability in age, education, and experience among the therapists. They ranged in age from 24 to 55 years and had an average age of 37. Years of experience providing drug-abuse counseling, services to adolescents, and services to families prior to beginning the study ranged from 0 to 23 years, with an average of 7 years of experience in each domain. Most had master's degrees ($n = 10$), but some therapists had bachelor's ($n = 6$) or doctoral ($n = 3$) degrees. Because two of the CYT sites were substance-abuse treatment agencies, the therapists from these sites worked in practice settings, and this was their first experience working in a research study or with manual-guided therapy. The other two sites were located in medical centers, where clinics were set up specifically for the CYT study. Five therapists from the medical-center-based clinics had participated in previous randomized field trials using manual-guided therapy.

Analysis

In the coding process, the unit of analysis included all the sentences or word segments in response to the interview questions. Therapists' responses were examined overall and by the particular manual(s) about which they were interviewed. Data sorting was facilitated with computer software that allowed grouping responses by each manual and coding key identification data with each response. Next, two investigators reviewed the transcripts line by line and developed the theoretical structure to guide further analysis. Major themes and subthemes were identified, coding labels were assigned to the identified themes, and their definitions were developed (Miles & Huberman, 1984). The investigators also identified four questions that appeared to address the most critical themes for independent coding: Compare and contrast doing therapy with and without a manual. What was the relationship, if any, between the assessment process and the delivery of the manualized therapy? Were there times when you deviated from the manual, and if yes, why? How was the manualized therapy able to meet the needs of each client? Using the coding categories, two independent raters assigned codes to the therapists' verbatim responses to the four questions and attained agreement rates of 92% or higher on all four questions. Responses from three additional questions were used to generate a list of recommendations for manual development.

RESULTS

Therapists' Perceptions of Manual-Guided Therapy

There were a number of themes that emerged as therapists talked about their experiences using the manuals. Table 1 shows a list of the six major themes and illustrates each one

Table 1. Major themes and representative quotes

Structure/Consistency
"It's also very structured; you know exactly the information that you need to present each time you meet with the participant. It is very clear—very concrete."
"The manual offers a substantial amount of structure in terms of what needs to be done in each of the five sessions."
"I think with a manual . . . it provides kind of the consistency approach. . . . All the clients get the same types of information."
Easy to Use
"With a manual, of course, the treatment is very prescribed and there are certain things designated to happen in each session. So, in that sense, it makes it somewhat easier."
"With the manualized treatment, I could just pick up session ten and just do it. With the nonmanualized-driven treatment, it takes a lot more preparation time."
"I would say that with the manual it's easy to do it as far as having it broken down into what types of things need to be done as a case manager."
Focus
"Using the manual does keep you honest in terms of what you should be doing."
"It certainly gives me a sense of where I need to go and I'm really attentive to where I and the family are going."
"I like the manual for . . . the ability to focus more on the individual clients needs than having to worry about constantly figuring out what I'm going to be doing for group."
Restrictive
"I think with a manual I feel a bit stilted and stunted in my style."
"Without one, of course, you have more freedom, you have more of an opportunity to sort of go with the flow more."
"Doing therapy with a manual is more constraining in having to only stick with interventions that are prescribed in the manual."
Incorporating Personal Style/Creativity
"I ran into some tougher kids, some much less receptive kids and that's when I had to be more creative."
"There's more room than some people may think to individualize and personalize the therapy with manual-driven treatment, and there is room for one to use one's creativity."
"It gives basic elements and then allows the clinician to use their own skill, in terms of exactly how it's communicated."
Flexibility/Opportunity for Client Centerness
"There's enough allowance for . . . taking the individuality of each of the participants into the style of which a given coping skill is taught and also there are role plays that . . . [allow] more of their individual issues that can be highlighted."
"It wasn't so rigid that it didn't allow for the ability to be creative, as far as the case management went, and I think it allowed [us] to meet the needs."
"It provides the framework or philosophy in which to deal with the client, but it doesn't restrict you in the flexibility to meet an individual kid's or family's needs; you can still deliver unique treatment."

with quotes from therapists. In this section, we present detailed descriptions of each major theme and describe (a) any variability in the therapists' responses related to different treatment manuals and examples of any contradictory views; (b) a set of themes related to the reasons therapists said they deviated (or why they did not deviate) from what was prescribed in a manual; and (c) a number of recommendations for developing manuals based on therapists' responses.

Structure and Consistency. A predominant theme described by all 19 therapists was that a treatment manual provided structure and consistency. They saw the manual as providing a structure or blueprint to their therapeutic work. They knew exactly what to do when, and there were clear principles to follow. They thought manuals ensured that all participants in an intervention were provided with the same information so there was consistency within a given therapeutic approach. The following examples illustrate the therapists' thoughts on the structure provided by the manuals: "Using the manual . . . it's also very structured; you know exactly the information that you need to present each time you meet with the participant. It is very clear, very concrete-that's the good thing about it" (MET/CBT5 therapist). "I'm enjoying the structure of this. I think it's really helpful for treatment centers [like ours]. I've managed the staff here and to have a developed program to train your clinicians on and say this is what we do helps the integrity of the program" (FSN family therapist).

Easy to Use. For many, the structure was a very positive aspect of using a manual because they liked the organization it provided for the session-based interventions (e.g., parent education of FSN) or the ability to check a manual for ideas when a supervisor was not readily available (e.g., MDFT). Thirty percent of the therapists said that following a manual made it easier to prepare for a session. As one therapist said: "With the manualized treatment, I could just pick up session 10 and just do it. With nonmanualized-driven treatment, it takes a lot more preparation time and analyzing and making sure you're not duplicating things and whether the kids in the group have seen [or] heard stuff before" (MET/CBT12 therapist).

Focus. Another theme described by six therapists from across treatments was that the manual helped them focus while in a session. They commented that they really had to concentrate during a session to be sure that they stayed on task and within the parameters of their manual. For example, one MDFT therapist noted that using a manual "sharpened his intentionality" and thus he was less likely to base the direction of a session on intuition.

Restrictiveness of Manuals. The second most prevalent theme discussed by the therapists was the restrictiveness of working with manual-based therapies. Some aspect of restrictiveness was described by 11 of the 19 therapists and cut across all the treatments. This theme was often mentioned before or after positive comments about the manual providing structure. The most frequently cited concern by therapists (8) was that following the manual limited their ability to respond to individual client needs. For example, one MET/CBT5 therapist noted that she would have liked to work with parents, but her intervention did not allow for parent/family work. Another therapist said:

It is hard to be where the client is or go with what the client needs because you have to stay exactly on task with the [manual]. So sometimes I find the client may start talking about something that I would think would be important for us to go with, but it's like I have to pull them back to, well, this is what we have to do in this session. [FSN family therapist]

The interventions with the highest percentage of therapists reporting that they felt restricted by the manual (70%) were those using one of the MET/CBT interventions. In fact, these comments were more directed to the CBT group component of the treatment. The most frequently voiced concern about the restrictiveness of the CBT groups was that the prescribed timing for particular topics did not always fit the group's needs or a particular group member's needs when they were timed to occur. One therapist aptly described the challenge of working with a group when she said, "Groups sort of have a life of their own and each one is different."

Incorporating Personal Style/Creativity. It is important to note exceptions, and four CBT therapists explained why they did not feel restricted by the manual. They described how they incorporated their personal style and creativity to make the intervention more relevant for participants. They used a 15-min check-in time during the group ses-

sion to build rapport with clients and talk about specific issues that were occurring in the clients' lives (e.g., court involvement, family break-up). They chose role play situations that were relevant to situations in participants' lives and changed vocabulary or examples used in the manual to make concepts more relevant to the group.

Flexibility Within an Intervention. Even though many therapists talked about the manuals being restrictive, the majority (with representation from each intervention) felt they were able to address unique needs of clients. Seventy-four percent of the therapists reported that the manual they used allowed them to address individual needs of clients (all of the ACRA and MDFT and all but one of the FSN family therapists are represented). The following quotes illustrate this theme:

I think the manual allows you to be able to go with what [the client] brings in. What the manual offers can work towards anything, so you can go wherever the client is, because the skills that you're offering aren't for specific types. (ACRA therapist)

I think [it was flexible because of] the emphasis on building a foundation with the family and getting the themes . . . the themes were common enough that most of the families were variations on those themes . . . . I think that there was flexibility in the manual to decide how much family sessions versus parent sessions versus individual sessions you could do. (MDFT therapist)

Not all therapists felt, however, that their intervention was able to meet the needs of individual clients. The following quote illustrates this viewpoint by one therapist:

When there's too much family chaos, when there's too much deviance, when the kid is out of school . . . I mean it is the thing with the Maslow hierarchy of needs, you know. When survival is what is eating you up, there is no point in coming and teaching religion. You're not going to get anyone to pay attention, you had much more basic needs. They were so anxious, there was a lot of other psychopathology going on, there was a lot of family conflict, a lot of hopelessness, a lot of environmental deviance. You're just this little small force compared to the ocean of opposite force that they are exposed to the whole day through. (MET/CBT5 therapist)

Table 2. Themes related to deviation from the manual

Serious Clinical Issues
"If there's something else going on with the family and the manual is not going to address it or it appears that I'm just ignoring something significant that's happening, I'll pull away from the manual."
"I would deviate from the manual particularly if there were issues of child welfare or protection or abuse or those kinds of things, obviously."
Logistics
"When only one participant showed, 45 min late, we didn't do the regular session."
"One time an entire group missed one session and didn't want to do a make-up, so I combined two group sessions."
Uncooperativeness
"One time because I knew the kids were not going to do the relaxation technique . . . I didn't necessarily have them practice it in the session."
"I would say the behavioral difficulty and the oppositionality of the participants sometimes makes it difficult to cover all of the essential elements of the session as well as I would like to."
"There are times I don't follow each session completely because kids are not into it; they are not responsive to the skills being taught."
Inappropriateness of Material
"I find that the fourth session as it was originally written in the manual was too detailed or . . . required a higher level of focus and cognitive ability than a lot of the adolescents can manage."
"Sometimes the therapists just felt like some of the rationale of why the kids should learn certain types of coping skills or some of the skill guidelines, were just so complex that they were losing kids' interest when trying to teach that."
"The kids said that some of the examples are not examples that happen to them in real life. And in many cases I would say, 'Okay, then can you give me an example?'"
Family Issues
"After the group session, I did a family therapy session . . . this kid got another form of intervention mixed up, but there wasn't really anything else I could do."
Broadness of the Manual (why there was no deviation)
"This family manual is broad enough to be pretty inclusive of almost anything you do."
"I think the topic areas are broad enough to address the needs the clients have."
"What the manual offers can work toward anything, so you can go wherever the client is, because the skills that you're offering aren't for specific types."

Deviations from the Manual

We asked the therapists if they deviated from the manual and if so, why. Six themes emerged (Table 2). Overall, six therapists said they never deviated from their manual, and two said they were not sure if they deviated. These eight therapists were equally divided across the ACRA, FSN, MET/CBT5, and MDFT interventions. Eight of the 10 therapists delivering one of the CBT interventions reported deviating from the manual. All three family therapists delivering the FSN intervention reported deviating from the manual for serious clinical issues, including finding a family in crisis on a home visit and intervening after a group participant disclosed a sibling was suicidal. The need to address serious clinical issues was the most common reason given (47% of the therapists) for deviating from the manual. Serious clinical issues included instances of rape, death of a friend, assault, and clinical deteriora-

tion. All but one of those therapists reporting deviation were providing one of the MET/CBT or FSN interventions. The following quotes are examples of therapists discussing deviation: "Yes . . . not so much for a whole session. [I deviated] two major times . . . [when we needed to] process life stressors. First, a client had a best friend die. Second, [when the] Columbine [High School] shooting happened" (MET/CBT5 therapist). "Yes, when the family is in crisis . . . For example, [when a] father [had a drinking problem] . . . and mom asked him to leave and then took him back, et cetera. When really bad fighting is going on sometimes the families need more basic [help] than what is in the manual" (FSN family therapist).

Several other themes emerged that characterized the reasons therapists deviated from manuals, including: (a) logistical reasons (i.e., no one showed up for a group session, so material for two group sessions were combined at the following meeting); (b) uncooperativeness and lack of motivation on the part of the participant; (c) inappropriateness of the material because it included too much detail or was at a higher cognitive level than their participants; and (d) the therapist's belief that a family meeting was important, when the manual did not include procedures for family involvement. The MET/CBT5 and MET/CBT12 interventions provided no guidelines for family involvement or case management. The difference those capabilities can make is illustrated by a quote from one therapist who provided the 12 MET/CBT sessions within the FSN intervention:

[FSN] takes the handcuffs off the boundaries that the MC12 manual had by allowing us to have more contact with juvenile justice workers, more contact with community resources to aid and assist a family, to make recommendations for psychological assessments, to help implement them getting transportation to and from therapy where the MC12 and MC5 [interventions] can't do that. (MET/CBT12 therapist in FSN)

The predominant reason given for not deviating from the manual was that the manual they were following was flexible or broad enough to accommodate the clinical material presented by most participants. The two individual-based interventions (ACRA and MDFT) and the individual-based MET that was part of the MET/CBT and FSN interventions all were viewed as allowing more flexibility than the group-based interventions that required certain material be covered in each session.

Therapist Recommendations for Adolescent Treatment Manuals

As part of the interview, therapists were asked to make recommendations about how to improve manuals. Three specific questions were asked. What did the therapist like most about the manual? What did they like least about the manuals? What did they think their manual was missing? Although some of the recommendations that follow would apply to any treatment manual, several are specific to adolescent treatment or substance-abuse treatment. Note that some of the recommendations that follow were incorporated into different CYT manuals initially or when they were revised. Recommendations offered were: (a) provide an overview of the philosophy behind the manual-guided treatment model; (b) provide an explanation of how assessment information can be used within the intervention; (c) describe therapy procedures with detailed explanations of each step involved; (d) provide specific content related to dealing with issues of drug addiction; (e) use language and examples that are appropriate for adolescents; (f) include samples of therapist-participant dialogue; (g) include examples of completed clinical paperwork; (h) provide guidance on how a therapist interacts with parents and guardians even if the approach does not include a family component; and (i) provide explicit directions about when (under what circumstances) it is appropriate to deviate from the manual or provide some general guidelines for addressing serious clinical issues (e.g., psychiatric problems, sexual abuse) within the context of the intervention.

DISCUSSION

Craighead and Craighead (1998) note that energy spent on debating the utility of treatment manuals could be better spent on improving the transportability of manuals to practice. The CYT study provides an opportunity to study manual transportability and generate recommendations for developing manual-guided therapies for adolescent substance abusers. Previous studies have examined therapists' views of treatment manuals in general (Addis & Krasnow, 2000; Najavits et al., 2000). One problem that Addis and Krasnow found was that fewer than 50% of the therapists they surveyed had a clear idea of what manuals were. The present study explored how therapists felt about a specific manual they had used. Five different treatment manuals were used in CYT, and they varied from being very structured and session based to being flexible, principle based, or procedure based. Also, the therapists

and case managers had different backgrounds than in the previous studies in which the majority of the respondents had a Ph.D. (the majority in this study had master's or bachelor's degrees). Only 5 of the 19 therapists had provided manual-guided therapy before. All were professional therapists (not graduate students), and almost all had provided therapy in regular practice settings. Similar to Najavits et al.'s (2000) findings, therapists were generally positive about treatment manuals. The interviews also provided data to evaluate the most common concerns about manual-guided therapy.

The first concern is that manuals do not allow therapists to address individual needs. In contrast, in this study, almost three-quarters of the therapists across all treatment conditions reported that they were able to address individual needs. This was particularly true for therapists using the principle- or procedure-based manuals (i.e., ACRA, MDFT), but some CBT group therapists also felt able to address individual needs through a creative approach to the intervention. In a clinical trial, researchers have to limit deviation from the manual, but few investigators would fault the kinds of modifications described by therapists in this study (e.g., addressing clinically urgent situations, using examples generated by participants rather than ones written in the manual). Therefore, even the most structured manuals can be, and maybe need to be, implemented allowing the therapist some degree of creativity.

The second concern is that manual-guided therapy does not work with the heterogeneous populations found in real practice settings. Analyses of sample characteristics reveals that CYT study participants were quite similar to adolescent substance-abuse clients seen in community outpatient treatment settings (Tims, 1999). In fact, two of the four study sites operated within existing community-based substance-abuse outpatient treatment agencies.

A third concern about manuals is that therapists who use them will have to conduct therapy in a rigid, step-by-step fashion that will negatively impact the therapy process. Addis and Krasnow (2000) found that practicing psychologists with more negative attitudes toward manuals viewed their use as dehumanizing the therapeutic process by emphasizing technique at the expense of flexibility and a strong therapeutic relationship. In contrast, most CYT therapists did not view the manuals as rigid. In fact, all therapists voiced some appreciation for the structure and consistency the manuals provided. Not surprisingly, therapists who delivered the group-based interventions that required certain material be covered in each session were more likely to express some frustration with the restrictiveness of the approach. However, none of the therapists felt their manual outlined "bad therapy" or an approach that they could not follow most of the time.

The most common reason therapists reported for deviating from the manual was to address serious clinical issues besides the presenting problem of substance abuse and dependence. They identified several common problems that occurred among the CYT adolescents, including physical abuse, depression, suicidal concerns, fear of pregnancy, criminal justice involvement, attention-deficit hyperactivity disorder, and being late for sessions. Carroll and Nuro (1996) have recommended that manuals be as comprehensive as possible and specifically address special problems that are congruent with the model or specify when other referrals may be necessary. The application of a manual might be enhanced by helping therapists distinguish between when they are deviating from a manual versus when they are providing ethical and responsible clinical treatment within the context of manual-guided treatment. Conflicts over this latter point probably have more to do with training and socialization of clinicians than with the restrictions of manuals themselves.

The CYT therapists echoed findings from Najavits et al. (2000) study when they recommended that manuals include practical information (e.g., detailed explanations of each step, examples of completed clinical paperwork). Several therapists noted that the intervention must be developmentally appropriate for adolescents. This recommendation has ramifications for the language, examples, visual aids, and any other material included in a manual. Examples should be as concrete as possible. Therapists also wanted specific guidelines for appropriate therapist-family interaction, even when the intervention did not necessarily focus on family as one of its core principles or procedures. Often therapists felt the need to contact parents or parents would initiate contact on their own. Not wanting to deviate from the manual, therapists were unsure how to handle these situations. Given the developmental dependency that adolescents have on their families, treatments targeting this population should have some provisions for including parents, even if limited. Without guidance regarding family interactions, it will be difficult to generalize a manual to practice settings (especially

when most substance-abuse programs already include some level of family involvement).

In addition to recommendations about manuals, 18 of the 19 therapists felt that clinical supervision was critical to implementing the manual-guided treatments. In addition to providing specific explanations regarding how to implement the manual procedures as designed, supervisors guided therapists in the flexible use of the manuals in challenging clinical situations. Intensive supervision is common practice in clinical trial research studies and may be the most active ingredient in obtaining good outcomes. Without intensive supervision in regular substance-abuse treatment settings, manuals may not produce expected results. Addis, Hatgis, Soysa, Zaslavsky, & Bourne (1999) provide a good overview of the complicated supervision issues that arise with manual-guided therapy and offer guidance for addressing them.

The further development and testing of treatment manuals in adolescent substance-abuse treatment can provide an impetus for advancing the effectiveness of treatment in practice settings. In this study, we attempted to describe therapist reactions toward different types of treatment manuals for adolescent substance-abuse treatment. Therapists helped illuminate both positive and negative aspects of manual-guided therapy and how manuals might be improved. It appears that evidence-based treatment manuals will continue to proliferate. The quality and acceptability of manuals can be enhanced by incorporating feedback from therapists.

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REFERENCES

Addis, M. E. (1997). Evaluating the treatment manual as a means of disseminating empirically validated psychotherapies. *Clinical Psychology: Science & Practice, 4,* 1–11.

Addis, M. E., Hatgis, C., Soysa, C. K., Zaslavsky, I., & Bourne, L. S. (1999). The dialectics of manual-based treatment. *The Behavior Therapist, 22,* 130–132.

Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting & Clinical Psychology, 68,* 331–339.

Addis, M., Wade, W., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology, 6,* 430–441.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Azrin, N. H., Sisson, R. W., Meyers, R., & Godley, M. (1982). Alcoholism treatment by disulfiram and Community Reinforcement Therapy. *Journal of Behavioral Therapy and Experimental Psychiatry, 13,* 105–112.

Brown, S. A., Myers, M. G., Mott, M. A., & Vik, P. W. (1994). Correlates of success following treatment for adolescent substance abuse. *Applied & Preventive Psychology, 3,* 61–73.

Budney, A. J., & Higgins, S. T. (1998). *A community reinforcement plus vouchers approach: treating cocaine addiction* (NIH Pub. No. 98–4309). Rockville, MD: National Institute on Drug Abuse.

Burglass, M., & Shaffer, H. (1981). The natural history of ideas in the treatment of the addictions. In H. Shaffer & M. Burglass (Eds.), *Classic contributions in the addictions* (pp. 33–35). New York: Brunner/Mazel.

Carroll, K. M. (1997). New methods of treatment efficacy research. *Alcohol Health & Research World, 21,* 352–359.

Carroll, K. M., Kadden, R. M., Donovan, D. M., Zweben, A., & Rounsaville, B. J. (1994). *Journal of Studies on Alcohol* (Supplement No. 12), 149–155.

Carroll, K. M., & Nuro, K. F. (Eds.). (1996). *The technology model: An introduction to psychotherapy research in substance abuse.* New Haven, CT: Yale University Psychotherapy Development Center.

Craighead, W. E., & Craighead, L. W. (1998, Fall). Manual-based treatments: Suggestions for improving their clinical utility and acceptability. *Clinical Psychology: Science and Practice, 5,* 403–407.

Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L. S., Muenz, L., Thase, M. E., Weiss, R. D., Gastfriend, D. R., Woody, G., Barber, J. P., Butler, S. F., Daley, D., Salloum, I., Bishop, S., Najavits, L. M., Lis, J., Mercer, D., Griffin, M. L., Moras, K., & Beck, A. (1999).

Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry, 5,* 493–502.

Crothers, T. D. (1891). Are inebriates curable? *Journal of the American Medical Association, 17,* 923–927.

Crothers, T. D. (1893). *The disease of inebriety from alcohol, opium and other narcotic drugs: its etiology, pathology, treatment and medico-legal relations*. New York: E. B. Treat.

Crothers, T. D. (1900). Editorial. *Journal of Inebriety, 22,* 483.

Dennis, M. L., Titus, J. C., Diamond, G., Donaldson, J., Godley, S. H., Tims, F. M., Webb, C., Kaminer, Y., Babor, T., French, M., Roebuck, M. C., Godley, M. D., Hamilton, N., Liddle, H., Scott, C., & the CYT Steering Committee. (in press). The Cannabis Youth Treatment (CYT) experiment: Rationale, study design, and analysis plans. *Addiction*.

Eifert, G. H., Schulte, D., Zvolensky, M. J., Lejuez, C. W., & Lau, A. W. (1997). Manualized behavior therapy: Merits and challenges. *Behavior Therapy, 28,* 499–509.

Godley, S. H., Godley, M. D., & Dennis, M. L. (2001). The assertive aftercare protocol for adolescent substance abusers. In E. Wagner & H. Waldron (Eds.), *Innovations in Adolescent Substance Abuse Interventions* (pp. 311–329). New York: Elsevier.

Godley, S. H., Meyers, R. J., Smith, J. E., Godley, M. D., Titus, J. M., Karvinen, T., Dent, G., Passetti, L., & Kelberg, P. (2001). *The adolescent community reinforcement approach for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 2*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Hamilton, N., Brantley, L., Tims, F., Angleovich, N., & McDougall, B. (2001). *Family support network for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 3*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L., Hall, J. A., Cone, L., & Fucci, B. R. (1991). Effects of a multisystemic therapy on drug use and abuse in serious juvenile offenders. A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly, 1,* 40–51.

Holloway, E. L., & Neufeldt, S. A. (1995). Supervision: Its contributions to treatment efficacy. *Journal of Consulting and Clinical Psychology, 63,* 207–213.

Kadden, R. M., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., Litt, M., & Hester, R. (Eds.). (1992). *Cognitive-behavioral coping skills therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Kalb, M., & Propper, M. (1979). The future of alcohology: Craft or science? *American Journal of Psychiatry, 133,* 641–645.

Kendall, P. (1998). Directing misperceptions: Researching the issues facing manual-based treatments. *Clinical Psychology: Science and Practice, 5,* 396–399.

Kendall, P. C., Chu, B., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing life into a manual: Flexibility and creativity with manual-based treatments. *Cognitive and Behavioral Practice, 5,* 177–198.

Lamb, S., Greenlick, M. R., & McCarty, D. (Eds.). (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment*. Washington, DC: National Academy Press.

Lambert, M. J., Chiles, J. A., Kesler, S. R., & Vermeersch, D. A. (1998). A compendium of current psychotherapy treatment manuals. In G. P. Koocher, J. C. Norcross, & S. S. Hill (Eds.), *Psychologists' desk reference*. New York: Oxford University Press.

Liddle, H. (2001). *Multidimensional family therapy for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 2*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Liddle, H. A., & Dakof, G. A. (1995). Family-based treatment for adolescent drug abuse: State of the science. In E. Rahdert & D. Czechowicz (Eds.) *Adolescent drug abuse: Clinical assessment and therapeutic interventions* (NIDA Research Monograph 156, pp. 218–254). Rockville, MD: National Institute on Drug Abuse.

Luborsky, L., & DeRubeis, R. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review, 4,* 5–14.

Mercer, D. E., & Woody, G. E. (1999). *An individual drug counseling approach to treat cocaine addiction: the collaborative cocaine treatment study model* (NIH Publication No. 99–4380). Rockville, MD: National Institute on Drug Abuse. (Available online at http://www.nida.nih.gov/TXManuals/IDCA/IDCA1.html.)

Meyers, R. J., Dominguez, T. P., & Smith, J. E. (1996). Community reinforcement training with concerned others. In V. B. Van Hasselt & M. Hersen (Eds.), *Sourcebook of psychological treatment manuals for adult disorders* (pp. 257–294). New York: Plenum Press.

Meyers, R. J., & Smith, J. E. (1995). *Clinical guide to alcohol treatment: the community reinforcement approach*. New York: Guilford Press.

Miles, M. B., & Huberman, A. M. (1984). Qualitative data analysis: A sourcebook of new methods. Newbury Park, CA: Sage.

Miller, W., & Hester, R. (1986). The effectiveness of alcoholism treatment. In W. Miller & R. Hester (Eds.), *Treating addictive*

behaviors: process of change (pp. 121–174). New York: Plenum Press.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1995). *Motivational Enhancement Therapy (MET) manual, Project Match*. Rockville, MD: National Institution Alcohol Abuse and Alcoholism.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: a coping skills training guide.* New York: Guilford.

Moras, K. (1993). The use of treatment manuals to train psychotherapists: Observations and recommendations. *Psychotherapy, 30,* 581–586.

Najavits, L. M., Weiss, R. D., Shaw, S. R., & Dierberger, A. E. (2000). Psychotherapists' views of treatment manuals. *Professional Psychology: Research & Practice 31,* 404–408.

Nowinski, J., Baker, S., & Carroll, K. (1992). *Twelve step facilitation therapy manual*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Sampl, S., & Kadden, R. (2001). *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for adolescent cannabis users: 5 Sessions, Cannabis Youth Treatment (CYT) Series, Volume 1.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Shoham, V., Rohrbaugh, M., & Steinglass, P. (1992). *Couples therapy for alcohol problems: A systemic treatment manual*. Santa Barbara, CA: UCSB Couples' Alcoholism Treatment Project.

Silverman, W. H. (1996). Cookbooks, manuals, and paint-by-numbers: Psychotherapy in the 90s. *Psychotherapy, 33,* 207–215.

Smith, J. E., Meyers, R. J., & Delaney, H. D. (1998). The Community Reinforcement Approach with homeless alcohol-dependent individuals. *Journal of Consulting and Clinical Psychology, 66,* 541–548.

Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition, and family/couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin, 122,* 1–35.

Stevens, S. J., & Morral, A. (in press). *Exemplary models for adolescent substance abuse treatment in America*. Binghampton, NY: Haworth Press.

Strosahl, K. (1998). The dissemination of manual-based psychotherapies in managed care: Promises, problems, and prospects. *Clinical Psychology: Science and Practice, 5,* 382–386.

Tims, F. (1999, August). Adolescent marijuana treatment clients: Characteristics and problem types. In J. M. Herrell, *Treatment of adolescent marijuana abuse: A randomized field experiment*. Symposium conducted at the 107th Annual Convention of the American Psychological Association, Boston, Massachusetts. (Available online at http://www.chestnut.org/LI/cyt/findings.)

Wagner, E. F., Brown, S. A., Monti, P. M., Myers, M. G., & Waldron, H. B. (1999). Innovations in adolescent substance abuse intervention. *Alcoholism: Clinical and Experimental Research, 23,* 236–249.

Webb, C., Scudder, M., Kaminer, Y., & Kadden, R. (2001). *The MET/CBT 5 supplement: 7 Sessions of Cognitive Behavioral Therapy for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 2*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

White, W. L. (1998). Slaying the dragon: The history of addiction treatment and recovery in America. Bloomington, IL: Chestnut Health Systems.

Wilson, G. T. (1996). Manual-based treatments: The clinical application of research findings. *Behaviour Research and Therapy, 34,* 295–314.

Wilson, G. T. (1997). Treatment manuals in clinical practice. *Behaviour Research and Therapy, 35,* 191–203.

Wilson, G. T. (1998). Manual-based treatment and clinical practice. *Clinical Psychology: Science & Practice, 5,* 363–375.

Yost, E. B., Wakefield, P. J., Williams, R. E., & Patterson, K. M. (1992). *Thoughts, actions, & alcohol: A cognitive-behavioral treatment manual for alcoholic couples*. Santa Barbara, CA: UCSB Couples' Alcoholism Treatment Project.

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