Brief COUNSELING *for* MARIJUANA DEPENDENCE

A Manual for Treating Adults

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Brief COUNSELING *for* MARIJUANA DEPENDENCE

A Manual for Treating Adults

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

Numerous people contributed to this document, which is part of the Marijuana Treatment Project (MTP) Cooperative Agreement. The document was written by Karen L. Steinberg, Ph.D., Roger A. Roffman, D.S.W., Kathleen M. Carroll, Ph.D., Bonnie McRee, M.P.H., Thomas F. Babor, Ph.D., M.P.H., Michael Miller, Ph.D., Ronald Kadden, Ph.D., David Duresky, M.A., and Robert Stephens, Ph.D. The MTP Research Group provided valuable guidance and support on this document. See appendix B for a full list of contributors.

This publication was developed with support from the Center for Substance Abuse Treatment (CSAT) to the University of Connecticut School of Medicine through Grant No. TI1 1323. This study was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), CSAT, U.S. Department of Health and Human Services (DHHS). The research was conducted in Farmington, Connecticut (UR4 TI1 1273 and UR4 TI1 1310), Miami, Florida (UR4 TI1 1274), and Seattle, Washington (UR4 TI1 1270), in cooperation with the following institutions: University of Connecticut Health Center, The Village South, Inc., University of Washington, and Evergreen Treatment Services. The publication was produced by Johnson, Bassin & Shaw, Inc. (JBS), under the Knowledge Application Program (KAP) contract numbers 270-99-7072 and 270-04-7049 with SAMHSA, DHHS. Christina Currier served as the CSAT Government Project Officer. Andrea Kopstein, Ph.D., M.P.H., served as the Deputy Government Project Officer. Jean Donaldson, M.A., served as Government Project Officer for the MTP Cooperative Agreement. Lynne McArthur, M.A., A.M.L.S, served as JBS KAP Executive Project Director; Barbara Fink, R.N., M.P.H., served as JBS KAP Managing Director; and Emily Schifrin, M.S., and Dennis Burke, M.S., M.A., served as JBS KAP Deputy Directors for Product Development. Other JBS KAP personnel included Candace Baker, M.S.W., Senior Writer; Elliott Vanskike, Ph.D., Senior Writer; Wendy Caron, Editorial Quality Assurance Manager; Frances Nebesky, M.A., Quality Control Editor; and Pamela Frazier, Document Production Specialist.

Disclaimer

The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of CSAT, SAMHSA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

All materials appearing in this volume except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors. Do not reproduce or distribute this publication for a fee without specific, written authorization from SAMHSA's Office of Communications.

Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), 800-729-6686 or 301-468-2600; TDD (for hearing impaired) 800-487-4889; or electronically through the following Web site: www.ncadi.samhsa.gov.

Recommended Citation

Steinberg, K.L.; Roffman, R.A.; Carroll, K.M.; McRee, B.; Babor, T.F.; Miller, M.; Kadden, R.; Duresky, D.; and Stephens, R. *Brief Counseling for Marijuana Dependence: A Manual for Treating Adults.* DHHS Publication No. (SMA) 05-4022. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2005.

Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

DHHS Publication No. (SMA) 05-4022
Printed 2005

TABLE OF CONTENTS

I. Introduction 1

Me? Hooked on Pot? 1
Case Examples 2
Brief Marijuana Dependence Counseling 3
Background 4
Current Findings About Marijuana Use 4
Overview of the Marijuana Treatment Project 5
Who Should Use This Manual? 7
Organization of This Manual 8

II. Overview of the Brief Marijuana Dependence Counseling Model and Manual 11

General Theoretical Assumptions 11
BMDC Therapeutic Tasks 13
Target Population 13
Structure of BMDC and the Individual Sessions 13
How To Use the Manual 14

III. Common Treatment Issues 15

Client–Counselor Relationship 15
Orienting the Client and Confidentiality 15
Preventing Attrition 16
Practice Exercises 18
Termination 18
Strategies for Addressing Common Clinical Problems 18
Summary 21

IV. Getting Started: Assessment Session 23

Building Rapport 23
Assessing Marijuana Use 23
Overview of Assessment Session: Building Rapport and Assessing Marijuana Use . . . 25
Assessment Session Protocol 26
Forms for Assessment Session 36

V. Enhancing Motivation: Sessions 1 and 2 63

Key Concepts: Motivational Interviewing Skills 63
Tips for the Counselor 69
Overview of Session 1: Reviewing the PFR 70
Session 1 Protocol 71
Overview of Session 2: Change Plan, Treatment Plan, and Supporter Involvement . . .78
Session 2 Protocol 79
Forms for Sessions 1 and 2 82

VI. Changing Marijuana Use Through Skill Building: Sessions 3 Through 9 97

Why Focus on Skills? 97
What Is Cognitive Behavioral Counseling? 98
Integrating MET and CBT 98
Tips for the Counselor 99
Overview of Session 3: Skill Topic 1, Coping With Other Life Problems 100
Session 3 Protocol 101
Overview of Session 4: Skill Topic 2, Understanding Marijuana Use Patterns 107
Session 4 Protocol 108
Overview of Session 5: Skill Topic 3, Coping With Cravings and Urges To Use 111
Session 5 Protocol 112
Overview of Session 6: Skill Topic 4, Managing Thoughts About Marijuana Use 116
Session 6 Protocol 117
Overview of Session 7: Skill Topic 5, Problemsolving 123
Session 7 Protocol 123
Overview of Session 8: Skill Topic 6, Marijuana Refusal Skills 127
Session 8 Protocol 127
Elective Skill Topics 131
Overview of Session 9: Elective Skill Topic 1, Planning for Emergencies and Coping With a Lapse 132
Session 9 Protocol: Elective Skill Topic 1 132
Overview of Session 9: Elective Skill Topic 2, Recognizing Seemingly Irrelevant Decisions 134
Session 9 Protocol: Elective Skill Topic 2 134
Overview of Session 9: Elective Skill Topic 3, Managing Negative Moods and Depression 138
Session 9 Protocol: Elective Skill Topic 3 139
Overview of Session 9: Elective Skill Topic 4, Demonstrating Assertiveness 142
Session 9 Protocol: Elective Skill Topic 4 142
Forms for Sessions 3 Through 9 145

VII. Supplemental Readings 167

Supplemental Reading A: Who Needs Treatment? The Nature, Prevalence, and Consequences of Marijuana Dependence 167

Supplemental Reading B: How Effective Is Treatment for Marijuana Dependence? The Marijuana Treatment Project and Related Studies 171

Supplemental Reading C: Implementing Brief Marijuana Dependence Counseling . .174

Appendix A. Session Rating Form 179

Appendix B. Contributors 185

Appendix C. Field Reviewers 187

References 189

SECTION I.
INTRODUCTION

The Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration, funded three clinical sites and a Coordinating Center (CC) to design and implement the Marijuana Treatment Project (MTP) in the late 1990s. A major focus of CSAT is rigorous testing of approaches to treat marijuana dependence in both adults and adolescents. MTP studied the efficacy of treatments for adults who are dependent on marijuana. At the time of funding, MTP was one of the largest Knowledge Development and Applications initiatives funded by CSAT. Another was the Cannabis Youth Treatment (CYT) Study, which resulted in the CYT Series, a five-volume resource that provides unique perspectives on treating adolescents for marijuana use (Godley et al. 2001; Hamilton et al. 2001; Liddle 2002; Sampl and Kadden 2001; Webb et al. 2002).

This manual for Brief Marijuana Dependence Counseling (BMDC) is based on the research protocol used by counselors in MTP. The manual provides guidelines for counselors, social workers, and psychologists in both public and private settings who treat adults dependent on marijuana. The 10 weekly one-on-one sessions in the BMDC manual offer examples of how a counselor can help a client understand certain topics, keep his or her determination to change, learn new skills, and access needed community supports (exhibit I-1). Stephens and colleagues (2002) describe the MTP rationale, design, and participant characteristics. Findings from MTP are presented in supplemental reading B of section VII.

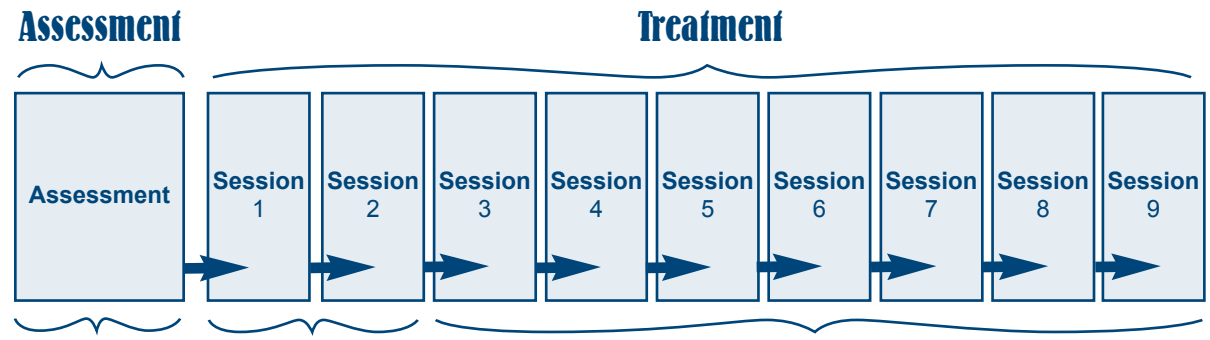
Me? Hooked on Pot?

Many individuals for whom this intervention was designed often have difficulty accepting that they are dependent on marijuana. The topic is controversial, even for those who walk through a counselor's door to talk about their marijuana use.

People who become clients in BMDC may have

- Put off actions and decisions to the point of being a burden on family and friends
- Given up personal aspirations
- Had nagging health concerns, such as worries about lung damage
- Made excuses for unfinished tasks or broken promises
- Experienced disapproval from family and friends
- Been involved in the criminal justice system.

Exhibit 1-1. Brief Marijuana Dependence Counseling



- Building rapport
- Motivational enhancement therapy (MET) techniques for engaging clients
- Overview for client

- MET
- Review of *Personal Feedback Report*
- Beginning cognitive behavioral therapy

- Core skill-building topics
- Elective skill-building topics
- Case management as needed

Case Examples

Doug

A Caucasian father of two teenagers, Doug was in his early 40s when his wife forced him to talk to a counselor about marijuana. He was not happy to be in the counselor's office. "What's the big deal?" he asked. "It's just pot." Doug's wife had given him an ultimatum: either he quit getting high or she would move out. She delivered this ultimatum when their 15-year-old son was suspended from school for smoking marijuana.

When they were younger, Doug and his wife smoked pot together. As their children grew older, however, his wife gave it up. For a long time, she tolerated Doug's continued use, with their agreeing that he'd be discreet. Both felt that the children should not know about his using. Doug tried to be careful, but a few times his son had walked in on him using marijuana.

"Why can't you settle for my promising to try harder to hide it from the kids?" he argued. "It's not as if it's really a problem. After all, our family benefits from my income."

Given what he said in the first several minutes he spent with the counselor, he saw the real issue as his wife's refusal to be reasonable. But Doug also mentioned that he wondered, "What will people think if word gets out that I smoke marijuana?"

Shirley

Shirley struggled with thoughts about marijuana and its effects. An African-American mother of three girls, Shirley was troubled by what she perceived as a conflict between her personal and professional lives.

Getting high helped her relax and sleep. Shirley had first smoked pot with a favorite uncle, and other members of her close-knit family had experienced getting high. No one was critical of her smoking. However, Shirley wanted to be an elementary school teacher. While student teaching, she was struck by the incongruity of having chosen a profession that called for being a good role model for children yet regularly getting stoned. She had thought a lot about quitting. When she tried to stop, she felt agitated and had difficulty sleeping. Shirley worried that she might not succeed in changing. She started seeing a counselor to sort out her confusion.

Like Doug, Shirley was grappling with a complicated issue. Doug and Shirley perceived aspects of their marijuana experiences as positive, yet they were troubled by possible consequences.

Miguel

A 36-year-old married Hispanic man, Miguel has known for years that getting high is no longer a casual part of his life. When he tried to stop, he got angry at the slightest provocation, could not relax, and inevitably returned quickly to frequent use.

Not too long ago, Miguel made an appointment at a drug treatment agency but never showed up. The agency employee who answered the phone asked him, “Is marijuana the only drug you use?” He thinks that he needs help but doubts that anyone would understand how he feels. He does not want to be treated like an addict.

Brief Marijuana Dependence Counseling

These three examples illustrate several important questions commonly asked by people about their marijuana use:

- Is it possible to be dependent on marijuana?
- Do I want to stop using because of what I’ve experienced?
- Can I succeed in stopping, given the challenges I’ve faced in the past?

The counseling approach presented in this manual addresses these issues among others. It comprises three key intervention components: motivational enhancement, cognitive behavioral skills training, and case management. Each session presents examples of how a counselor might introduce certain topics, facilitate the client’s resolution to stop using marijuana, provide skills training, and help the client access needed community supports.

Background

Before 1994, no published, controlled trials of treatment for marijuana use disorders existed, which is surprising because marijuana long has been the most frequently used illicit substance in the United States. Interest in treatment for people who use marijuana may have been lacking because of myths that extensive marijuana use did not lead to dependence and that no adverse consequences were associated with misuse (Roffman et al. 1988; Stephens and Roffman 1993). The relatively mild withdrawal symptoms associated with marijuana use may have led to a belief that dependence was unlikely and that people who needed treatment abused other substances and their marijuana use was a secondary concern (e.g., Rainone et al. 1987). Similarly, most early reviews found few serious negative consequences associated with marijuana use (e.g., Hollister 1986; Wert and Raulin 1986*a*, 1986*b*). However, recent research shows that a significant number of adults are dependent on marijuana and experience negative consequences secondary to their use of marijuana.

Current Findings About Marijuana Use

Marijuana is the most commonly used illicit substance in the United States (Clark et al. 2002; Substance Abuse and Mental Health Services Administration 2003). According to the 2003 National Survey on Drug Use and Health, 14.6 million people ages 12 and older had smoked marijuana in the preceding month (Substance Abuse and Mental Health Services Administration 2004). It is estimated that approximately 4.3 million people used marijuana at levels consistent with abuse or dependence in the past year. Given that it is an illicit substance, any use of marijuana carries with it some significant risks. However, this document focuses on people who use marijuana heavily or are dependent on it. This treatment manual is directed primarily at these persons but may be useful for other persons with substance abuse or substance use disorders.

Studies have demonstrated that tolerance and withdrawal develop with daily use of large doses of marijuana or THC (Haney et al. 1999*a*; Jones and Benowitz 1976; Kouri and Pope 2000). About 15 percent of people who acknowledge moderate-to-heavy use reported a withdrawal syndrome with symptoms of nervousness, sleep disturbance, and appetite change (Wiesbeck et al. 1996). Many adults who are marijuana dependent report affective (i.e., mood) symptoms and craving during periods of abstinence when they present for treatment (Budney et al. 1999). The contribution of physical dependence to chronic marijuana use is not yet clear, but the existence of a dependence syndrome is fairly certain. An Epidemiological Catchment Area study conducted in Baltimore found that 6 percent of people who used marijuana met *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) (American Psychiatric Association 1994), criteria for dependence and 7 percent met DSM-IV criteria for substance abuse (Rosenberg and Anthony 2001). Coffey and colleagues (2002) found that persons who use marijuana more than once a week are at significant risk for dependence. In the 1990s, the number of people who sought treatment for marijuana dependence more than doubled (Budney et al. 2001). Therefore, a large group of adults who smoke marijuana is dependent and may need and benefit from treatment.

Surveys of people using marijuana who are not in treatment consistently show that a majority report impairment of memory, concentration, motivation, self-esteem, interpersonal relationships, health, employment, or finances related to their heavy marijuana use (Haas and Hendin 1987;

Rainone et al. 1987; Roffman and Barnhart 1987; Solowij 1998). Similar marijuana-related consequences are seen among those seeking treatment for their marijuana use (Budney et al. 1998; Stephens et al. 1994*b*, 2000). People using marijuana who participated in previous treatment studies averaged more than 10 years of near-daily use and more than six serious attempts to quit (Stephens et al. 1994*b*, 2000). These individuals had persisted in their use despite multiple forms of impairment (i.e., social, psychological, physical), and most perceived themselves as unable to stop.

During the past decade evidence has emerged that a variety of problems are associated with chronic marijuana use. Although the severity of these problems appears to be less than that of problems caused by other drugs and alcohol, the large number of people using who may have these problems raises the possibility of a significant public health problem. Like those who use other mood-altering substances, many individuals who use marijuana chronically perceive the problems to be severe enough to warrant treatment.

The results of earlier studies on treatments for marijuana problems indicated that some adults who used marijuana responded well to several types of interventions, such as cognitive behavioral, motivational enhancement, and voucher-based treatments (Budney et al. 2000; Stephens et al. 1994*b*, 2000). Relapse rates following treatment were similar to those for other drugs of abuse and, as found with other types of substance abuse treatment, improvements in drug use were accompanied by other positive gains, including improvements in dependence symptoms, problems related to marijuana use, and anxiety symptoms. However, the generalizability of the treatment findings appeared to be limited by the predominantly white, male, and socioeconomically stable (i.e., educated and employed) characteristics of the samples. Therefore, the results of these studies may be limited to this fairly homogeneous group of people who are marijuana users.

Overview of the Marijuana Treatment Project[1]

CSAT funded MTP to design and conduct a study of the efficacy of treatments for marijuana dependence, to extend this line of research, and to broaden the applicability of the approach to a more diverse group than that used in earlier trials (Stephens et al. 1994*b*, 2000). The treatment sites were the University of Connecticut School of Medicine, Department of Psychiatry, Farmington, Connecticut; The Village South, Miami, Florida; and the University of Washington, School of Social Work, Seattle, Washington. The CC was at the University of Connecticut, Department of Psychiatry.

The study examined the efficacy of treatments of different durations for a diverse group of adults who were marijuana dependent. Two treatments—one lasting two sessions, the other nine sessions—were compared with a delayed treatment control (DTC) condition, in which subjects were offered treatment 4 months after their baseline assessment. The same counselors delivered treatments of both durations to avoid confounding the mode of treatment, length of treatment, and counselor experience. A case management component was incorporated in the longer treatment to help clients identify and overcome barriers to successful behavior change in their everyday environments. The hypothesis was the nine-session and two-session interventions would produce outcomes superior to the DTC in terms of higher abstinence rates and associated negative consequences. Although the

[1]The following section is adapted from MTP Research Group (in press).

limited prior research suggested no differences between brief and extended treatments, it also was hypothesized that the nine-session intervention would yield outcomes superior to the two-session intervention when delivered by counselors with the same level of expertise.

The study improved on the methodology of the previous treatment studies in several other ways. Structured diagnostic interviews were used to arrive at formal diagnoses of marijuana dependence, and the Addiction Severity Index, a widely used measure of problem severity, was included to compare the findings of this study with those of other studies of drug abuse. Supplemental reading B in section VII provides a detailed discussion of study methodology.

As the first well-controlled multisite trial of manual-guided treatments for marijuana dependence, this study produced several noteworthy findings:

- The results of the randomized trial suggest that both a two-session motivational enhancement therapy (MET) treatment and a nine-session treatment incorporating MET, coping skills training, and case management were significantly more effective in reducing marijuana use than a DTC condition.
- The more intensive the treatment, the better the outcomes.
- Outcomes of these brief treatments were durable; data from a 1-year followup of the treated groups demonstrated treatment's sustained effect even after treatment termination.
- Reductions in drug use were linked to other positive outcomes (e.g., sustained reductions in marijuana-related problems).
- Treatment effects were robust across a number of participant characteristics, including gender and ethnicity.

Taken together, these findings suggested that treatment for marijuana dependence was effective.

Few studies have evaluated active treatments with respect to a DTC condition. The findings from the DTC group are not consistent with the view that marijuana dependence is benign and that individuals improve without treatment. Instead, these findings suggest that well-structured treatments may be necessary to increase abstinence rates among the chronic marijuana-using population. Many subjects reported difficulties finding help for their marijuana-related problems through the current substance abuse treatment system.

The findings are also generally consistent with the results of prior studies of behavioral treatments for cannabis-related disorders (Budney et al. 1998; Stephens et al. 1994*b*, 2000) in suggesting that well-defined behavioral treatments for marijuana dependence produce encouraging improvement and that treatment is associated with meaningful benefits. These findings support other results in the literature pointing to the efficacy of behavioral treatments in producing significant and durable improvement for a range of substance-related disorders, particularly alcohol and cocaine dependence.

Findings indicate a robust dose-effect relationship for this study's treatments and contrast with earlier studies of cannabis treatment that have not demonstrated differences in outcome related to intensity. The MTP study, one of only a few studies that have focused on treatment intensity,

contrasted the brief two-session treatment with the more intensive nine-session treatment; treatment participation was high in both conditions. However, further research is needed to determine whether treatment outcomes might be improved with more treatment or whether different distributions of treatment sessions might help people who use marijuana sustain the positive treatment outcomes.

In addition to the overall reductions observed in the frequency of marijuana smoking, reductions also were evident in marijuana dependence symptoms, marijuana-related problems, and anxiety symptoms. In each measure, the nine-session treatment group showed the greatest improvements, the two-session group showed intermediate reductions, and the DTC group showed little change.

Finally, countering the historical portrayal of marijuana as a benign drug, the MTP study and previous research (Stephens et al. 1993*a*, 1994*b*, 2000) suggest that individuals can develop recurrent psychological, social, and medical problems with chronic marijuana use. Individuals who use marijuana as their primary drug tend not to seek treatment in traditional drug treatment settings. Clients in real-life treatment settings, as compared with volunteers in randomized clinical trials, tend to present with complex difficulties in addition to substance use disorders. When people present for marijuana treatment, they may want and need help with family and other relationships, regulating their emotions, employment and financial problems, or addressing health worries. These problems may have preceded, resulted from, or co-occurred with the substance use difficulties. Increasing evidence suggests that counseling for marijuana dependence is effective and accompanied by other positive changes in clients' lives (Steinberg et al. 2002).

Who Should Use This Manual?

The manual is designed for use by experienced clinicians. Counselors should follow the outlined procedures and should have the opportunity for regular consultation with clinical supervisors familiar with the BMDC approach. Detailed treatment protocols define goals for each session and standardize counseling techniques but also permit flexibility.

All BMDC counselors should meet the following criteria:

- A master's degree in counseling, psychology, social work, or a closely related field
- At least 2 years of clinical experience after completion of degree or certification
- Experience in conducting treatment consistent with BMDC
- Experience in treating people who abuse or are dependent on drugs or alcohol.

This manual is a blueprint for treatment and is not a substitute for training and supervision. The material may not be appropriate for all clients or clinical programs. This manual should be viewed as a supplement to careful assessment of each client, appropriate case formulation, monitoring of clinical status, and clinical judgment.

Supplemental reading C in section VII provides detailed information on effectively implementing and managing BMDC; appendix A provides a session rating form to guide supervisors.

Organization of This Manual

Section II. Overview of the Brief Marijuana Dependence Counseling Model and Manual

Section II describes the theoretical basis for BMDC treatment. It explains the therapeutic tasks of the BMDC approach, describes the target population, and provides an overview and the suggested sequencing of BMDC sessions.

Section III. Common Treatment Issues

Section III presents potential pitfalls in BMDC and guidelines for handling issues that may arise. Some problems identified are not specific to marijuana treatment and may apply generally to substance use disorders or clinical counseling.

Section IV. Getting Started: Assessment Session

Section IV details the strategies for initiating BMDC treatment with a client dependent on marijuana. The assessment session outlines strategies for building rapport, assessment procedures, and MET techniques for engaging the client and identifying goals and change strategies. Clinical information for assessing and evaluating the client's status, level of marijuana use, problems related to use, and reasons for wanting to change is gathered by the counselor during the initial evaluation and is used to develop an individualized treatment plan. The session includes assessment and scoring tools for completing a client's *Personal Feedback Report* (PFR), a critical tool in the implementation of BMDC.

Section V. Enhancing Motivation: Sessions 1 and 2

Sessions 1 and 2 of BMDC follow MET principles. During session 1, the counselor uses the completed PFR to make the client aware of the effects of marijuana use on critical life areas and to increase motivation. Using motivational interviewing strategies, the counselor elicits and reinforces the client's motivation for change. If the client is ready to change, the discussion shifts from motivational enhancement to cognitive behavioral strategies, goal setting, and the skills to accomplish goals. The guidelines for session 2 instruct the counselor on how to reinforce the client's efforts to initiate change, review goals and plan alternative strategies for behavior change, and encourage support from the friend or relative who has been invited to the session by the client.

Section VI. Changing Marijuana Use Through Skill Building: Sessions 3 Through 9

Section VI outlines material for the remaining seven sessions of BMDC, including the use of cognitive behavioral strategies for building client motivation and maintaining treatment gains. This section describes the six core skill topics and four elective skill topics used with clients in BMDC (exhibit I-2).

Exhibit I-2. Core and Elective Skill Topics in Brief Marijuana Dependence Counseling
Core Skill Topics (sessions 3ñ8)
Session 3: Coping with other life problems Session 4: Understanding marijuana use patterns Session 5: Coping with cravings and urges to use Session 6: Managing thoughts about marijuana use Session 7: Problemsolving Session 8: Marijuana refusal skills
Elective Skill Topics (session 9)
Topic 1: Planning for emergencies and coping with a lapse Topic 2: Recognizing seemingly irrelevant decisions Topic 3: Managing negative moods and depression Topic 4: Demonstrating assertiveness

The counselor and client jointly select one of the four elective topics that they decide is most appropriate. The guidelines for sessions 3 through 9 are twofold:

- The sessions follow detailed protocols for using cognitive behavioral skills to build on client strengths and to overcome specific skill deficits associated with substance dependence.
- The sessions identify other problems that can interfere with recovery from marijuana dependence and suggest clinical case management interventions.

Section VII. Supplemental Readings

A. Who Needs Treatment? The Nature, Prevalence, and Consequences of Marijuana Dependence

This section provides a comprehensive review of the literature on the epidemiology of marijuana dependence, the significance of the problem, and the rational for developing effective and replicable treatments.

B. How Effective Is Treatment for Marijuana Dependence? The Marijuana Treatment Project and Related Studies

This section presents the design, rationale, and findings from major clinical trials that have focused exclusively on marijuana dependence treatment, including MET.

C. Implementing Brief Marijuana Dependence Counseling

This section is intended for program developers, administrators, and supervisors who are responsible for establishing and maintaining an infrastructure to support clinical implementation of BMDC. These guidelines can be used in identifying an appropriate site for BMDC, selecting and supervising counselors, easing the transition to marijuana-specific treatment, and monitoring effectiveness.

SECTION II.
OVERVIEW OF THE BRIEF MARIJUANA DEPENDENCE COUNSELING MODEL AND MANUAL

The Brief Marijuana Dependence Counseling (BMDC) approach combines elements from previously demonstrated treatments for substance use disorders:

- Motivational enhancement therapy (MET) (CSAT 1999*b*; Miller and Rollnick 2002)
- Cognitive behavioral therapy (CBT) (CSAT 1999*a*; Kadden et al. 1994; Monti et al. 1989)
- Case management (CSAT 1998).

MET strategies are perceived as potentially useful with the chronic marijuana-using population because of their success in addressing substance use disorders.

The client-centered engagement approach of MET is a good fit for individuals who, in many cases, never have been involved in treatment before and have been frustrated with previous attempts at locating marijuana-specific treatment opportunities. MET provides the overall theoretical framework, and specified MET strategies are used heavily during sessions 1 and 2. Although the remaining seven sessions focus increasingly on skill building rather than motivation, MET concepts and strategies are incorporated throughout all treatment sessions. The counselor is encouraged to pay attention to the client's readiness for change and its implications for treatment engagement and behavioral and attitudinal changes.

CBT provides a secondary, but complementary, approach in the BMDC model. The CBT sessions focus on building the client's behavioral, cognitive, and emotional skills necessary to undertake a major life change such as stopping marijuana use.

The case management components are introduced in session 3, which is devoted to identifying life problems that are extraneous to or aggravated by the client's marijuana problems. The counselor teaches the client how to access support services to address these additional problems.

General Theoretical Assumptions

Clinical Engagement and Therapeutic Alliance

BMDC fosters the development of a strong working alliance between counselor and client to explore marijuana-related problems, identify realistic goals, and initiate change strategies. From the outset of treatment, the counselor focuses on engaging the client in the treatment process by establishing trust and showing an accurate reflection of the client's concerns. Throughout treatment, the counselor demonstrates respect, warmth, and empathy and shows concern for the client's needs. Any disruptions to the therapeutic relationship are handled carefully and respectfully.

Meeting Clients "Where They Are"

The counselor develops a clear picture of the client's past and current marijuana use upon admission to treatment, the problems that have been created through continued use, the reasons the client has identified for making lifestyle changes related to marijuana, and the goals the client wants to achieve. An understanding of where the client is on his or her particular path to abstinence helps the counselor guide growth and change. The counselor listens to the client's core concerns about marijuana and his or her treatment goals and provides an environment that motivates the client to take steps toward recovery. The counselor does not impose goals or values during the treatment process, nor does he or she communicate disapproval or judgment about the client's objectives or readiness to change. Rather, the counselor encourages the client to express his or her goals and to participate in developing objectives. This approach presents an apparent conundrum: the client's goal of abstinence will be served by the therapist's not demanding abstinence of the client immediately upon entering treatment. It is important to note that meeting clients "where they are" is a therapeutic necessity that is consistent with a goal of abstinence.

The client-centered aspects of MET and case management allow the counselor to adjust session content to a client's background and culture (Steinberg et al. 2002). Focusing on the individual is not meant to preclude the client's participating in mutual-help or 12-Step programs between sessions. If the client shows an interest in attending such groups, the counselor should make available a list of local meetings.

Supporting Client Efficacy and Pointing Out Discrepancies

As the BMDC counselor engages the client in treatment and establishes a positive working relationship with him or her, the counselor looks for opportunities to refine goals and examine motivation levels. The counselor achieves this in a variety of ways, including supporting the client's efficacy and pointing out discrepancies. Supporting client efficacy is essential because it communicates belief in the client's inherent wisdom and ability to solve problems effectively. The counselor conveys the message that, although treatment entails learning new techniques or skills for handling difficult problems, the client possesses the ability to learn, process information, and carry out his or her plans. Discrepancies may exist between goals and behaviors, previously stated and currently stated concerns, or perceived benefits and actual consequences of marijuana use. By pointing out these discrepancies or inconsistencies to the client the counselor can enhance the client's motivation and determination.

Learning About Marijuana Use Patterns

The BMDC model is based on the principle that substance use disorders result from learned behavior patterns rather than basic character defects. The counselor presents this framework to the client as a way of both understanding how the client's problems developed and thinking about how to ameliorate the situation. For example, marijuana dependence can result from repeated use to relieve painful emotions or to self-medicate. Therefore, recovery from marijuana dependence requires making new choices involving healthier lifestyle patterns.

BMDC Therapeutic Tasks

BMDC is a short-term treatment to assist clients. The BMDC counselor engages the client in a treatment process that builds on the client's motivation to change. The approach integrates several models and accompanying strategies and is flexible within the general treatment structure. The BMDC treatment approach can be tailored to specific clinical situations while retaining its specific set of therapeutic tasks. Those tasks include

- Encouraging therapeutic engagement
- Performing a thorough assessment of the client's marijuana problem, as well as his or her strengths and resources
- Facilitating motivation for change
- Addressing psychosocial problems beyond marijuana use
- Building skills to establish and sustain change.

Client factors such as marijuana problem severity, general acuity, and psychosocial stresses and supports determine when activities to address these tasks are initiated.

Target Population

BMDC is for people seeking treatment to stop their marijuana use. People with a pattern of long-term marijuana use may have chronic symptoms of physiological and psychological dependence as well as impairments in other life areas, such as family relationships, intrapersonal and interpersonal capabilities, work, and educational achievement. BMDC has been effective with clients who participate voluntarily, but whether it would be effective with individuals who are mandated to treatment is not known. BMDC appears to be effective with clients who are ambivalent about stopping their marijuana use; in fact, the treatment model helps clients explore and resolve such ambivalence (Steinberg et al. 2002). BMDC has been used in outpatient treatment settings with individuals who require a low intensity of service. With clients who require more intensive services or who have significant co-occurring disorders, BMDC may be used adjunctively with other treatments but should not replace needed services.

Structure of BMDC and the Individual Sessions

BMDC comprises nine sessions that are organized into three sections:

- Getting Started: Assessment Session
- Enhancing Motivation (sessions 1 and 2)
- Changing Marijuana Use Through Skill Building (sessions 3 through 9).

Each section begins with an introduction that provides an overview of the basic rationale, goals, counselor skills, and client activities that are used in the sessions in that section. The introduction is followed by an overview and a specific protocol for each session.

Each session description begins with a box that provides the following information:

- Session Title
- Total Time
- Delivery Method
- Materials
- Goals for This Session
- Session Outline, including the major subheadings and points to remember.

The box is followed by a detailed protocol that walks the counselor through the session content, provides session-specific background information and rationale, and offers samples of interactions between counselor and client. *Italicized text* is used to denote a sample script of what a counselor might say to a client to illustrate a principle, an example of a possible dialog between a counselor and a client, or an example of a role play between a counselor and a client.

Although each weekly session is unique in content, each includes the following three phases:

- **Check-in.** This includes asking the client about recent events, progress made, and any lapses that may have occurred since the last session. The counselor also reviews any between-session exercises assigned during the previous session.
- **Presentation of the session material or skill topic.** This phase is presented in detail in the session protocol.
- **Summary.** The counselor briefly summarizes the session, asks the client whether he or she understands major points covered, and provides clarification as necessary.

How To Use the Manual

The counselor should read through the entire manual before beginning treatment. Counselors should have basic training in both motivational enhancement and cognitive behavioral treatment techniques, but the manual provides a solid review of basic principles and information specific to working with clients who are marijuana dependent. Supplemental reading C in section VII provides details on BMDC-specific training.

The detailed session protocols are not designed to be taken into a session and followed literally. They offer the counselor suggestions on how to transition from one topic to the next during a session. The counselor needs to become familiar with the session content before meeting the client. However, the boxed overview and outline at the beginning of each session can be pulled out of the manual and taken into the session to be used as a cue sheet.

The forms used in each session are at the end of that section. Counselors should make copies of the forms before each session for their clients.

SECTION III.
COMMON TREATMENT ISSUES

This section highlights problems that may arise when working with people who are dependent on marijuana. Clients in Brief Marijuana Dependence Counseling (BMDC) may differ from clients with mental disorders and from clients who abuse other substances. For example, this may be the client's first experience in any type of treatment setting. Clients may be uncertain about what they are supposed to do in therapy. To alleviate feelings of uncertainty, a counselor can provide clients with general information about the client–counselor relationship and treatment expectations and parameters.

ClientñCounselor Relationship

In BMDC the client–counselor relationship is at the core of the change process; a positive relationship is the foundation of treatment. Even though BMDC treatment is brief, the quality of the relationship is important.

A strong relationship positively affects compliance and retention. The counselor can promote the therapeutic relationship through listening empathically, providing support and encouragement, displaying genuine concern, responding to client concerns, addressing disagreements promptly, and providing clarifications and explanations.

The counselor should avoid strategies that may elicit resistance, including aggressive confrontation of denial, excessive questioning, interrupting the client, or arguing with the client. The counselor should respond to client concerns and complaints while providing a consistent structure for the sessions. Clients who have never participated in psychotherapy or psychosocial treatment may need extra guidance about the process of treatment to foster therapeutic engagement.

Orienting the Client and Confidentiality

As part of the assessment session, the counselor spends time describing the treatment and session format and answering questions. The counselor provides an overview at the beginning of each session and spends a few minutes at the end summarizing the topics addressed to help the client develop a framework for the sessions and retain the material that was discussed.

The counselor also should discuss confidentiality issues during the assessment session. The client may be unfamiliar with the confidentiality of information disclosed in therapy and the limits to confidentiality. He or she may need updated information on new rules such as the Health Insurance Portability and Accountability Act. Although the client may have signed an informed consent or other admissions forms, the counselor should not assume that the client understands the issues surrounding confidentiality; it is good clinical practice to discuss them.

Preventing Attrition

During the assessment session, it is important to anticipate potential obstacles to successful treatment, especially factors that can lead to early attrition. The counselor should explore any instances in which the client previously dropped out of treatment and urge the client to discuss any thoughts of quitting treatment. Open discussion can resolve problems and prevent the client from dropping out. Progress in treatment is not steady—there are ups and downs. Most clients experience hopelessness, anger, frustration, and other negative feelings at times. Clients should be encouraged to discuss their feelings, even if they fear that the discussion might be embarrassing or difficult.

The counselor can point out that prematurely terminating treatment may be one of a series of seemingly irrelevant decisions that eventually lead to a relapse. For this reason, any hint that a client is considering dropping out should be taken seriously and discussed fully.

Many clients quit treatment after their first relapse. Clients should be warned that, even with efforts to maintain abstinence, some might slip and begin using. They should be encouraged to continue attending after a using episode so that they can receive help in regaining abstinence, coping with their reaction to the slip, and avoiding future lapses.

A delicate balance exists between setting the stage for clients to feel they may return after a lapse and giving them permission to use. Counselors should ensure that clients understand this distinction clearly.

Recognizing Change Readiness

Following is a list of questions to assist counselors in determining clients' readiness to accept, continue in, and comply with a change program (Zweben and O'Connell 1988):

- Has the client missed previous appointments or canceled sessions without rescheduling?
- If the client was coerced into treatment, have his or her reactions—anger, relief, confusion, acceptance—to this forced attendance been discussed?
- Is the client hesitant to schedule future sessions?
- Is treatment different from what the client has experienced before? If so, have the differences and the client's reactions been discussed?
- Does the client seem guarded during sessions? Is he or she hesitant or resistant when a suggestion is offered?
- Does the client perceive treatment to be a degrading experience rather than a new lease on life?

If the answers to these questions suggest a lack of readiness for change, the counselor may explore the client's uncertainties and ambivalence about abstinence and change. This could be an opportunity to use motivational enhancement therapy (MET) strategies to enhance client determination.

The counselor should proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment committed to change, his or her motivation should be assessed before beginning treatment. Likewise, the counselor should not assume that, once the client has decided to change, he or she will no longer experience ambivalence.

Ambivalence

If the client is reluctant to commit to making a change in behavior, the counselor should not push too hard. If the client commits to a change he or she is not ready to make, he or she may drop out of treatment rather than renege on an agreement. Premature commitment evokes resistance and undermines the MET process.

The counselor should not assume that ambivalence has been resolved and commitment is firm. It is safer to assume that the client is still ambivalent and to continue using motivation-building and commitment-strengthening strategies.

The counselor should reflect and explore the client's expressions of uncertainty and ambivalence. It can be helpful to "normalize" ambivalence and concerns, for example:

Counselor (C): *What you're feeling is quite common, especially in these early stages. Of course you're feeling confused. You're still attached to smoking, and you're thinking about changing a pattern that has developed over many years. Give yourself time.*

The counselor also should reinforce any self-motivational statements and indications of willingness to change and provide reassurances that people can change, often with only a few consultations. The client may reconsider resistance to change after accepting that the counselor understands his or her reasons for being hesitant to change. Alternatively, pushing the client may result in a treatment dropout.

Treatment Dissatisfaction

A client may say that the treatment is not going to help or may want a different treatment. The counselor should first reinforce the client's honesty. The counselor should confirm that the client has the right to quit treatment at any time (unless mandated into treatment), seek help elsewhere, or decide to work on the problem in another way. The counselor should explore the client's feelings further. Concerns that arise in the first session are probably reservations about an approach the client has not tried. No one can guarantee that a particular treatment will work, but the counselor can encourage the client to try it for the planned period. The counselor can add that, should the problem continue or worsen, other possible approaches can be discussed.

Compliance Enhancement Procedures

A variety of strategies can facilitate compliance and overall client retention in treatment. They include devoting time to educating clients about treatment participation, treatment expectations, and potential barriers to involvement in treatment, such as transportation or childcare needs and work or school conflicts.

Didactic Material

The counselor gives brief presentations of the material in clear and concise language. It is important not to overload clients with too much material or use a lot of jargon. At the end of each session, the counselor asks whether the client understands major points of the presentation rather than assumes that the client comprehends.

Practice Exercises

Whenever possible, the counselor encourages the client to complete between-session practice exercises. The counselor provides a careful rationale and description of the exercise, gives specific instructions, and explains how the task relates to treatment goals. The counselor ensures that the client understands each practice exercise, follows up on between-session exercises during the next session, and examines obstacles. When the counselor ignores noncompliance with the exercise, early dropout may follow.

Termination

Termination can be a problem for many clients and can lead to clinical deterioration or some emotional dysregulation just before the end of treatment. Several weeks before the last session, the counselor should review the treatment timetable to sensitize himself or herself and the client to termination issues. Session 6 is a good time to broach the topic of termination. The degree of attention to termination can vary according to the client. As the end of treatment nears, it is useful to remind the client of the number and the topics of the sessions remaining and respond to the client's reactions.

The final session explores one of four elective skill topics, but the counselor should ensure that enough time is devoted to termination issues. Whatever the structure or content of the final session, the counselor must allow sufficient time to process the ending of treatment with the client. Processing includes summarizing what happened in treatment, discussing aspects of treatment that were most helpful and least helpful from the client's perspective, eliciting client reactions and feelings about treatment, and exploring next steps for the client.

Strategies for Addressing Common Clinical Problems

The counselor should respond to common clinical problems in a manner consistent with the treatment approach, that is, reflection and reframing that follow the principles of MET and, when indicated, a more active problemsolving approach.

Counselor's Response to Missed Session

The counselor should attempt immediately to phone a client who does not show up for a scheduled therapy session to find out why the session was missed. Clients sometimes miss sessions because they slipped and are embarrassed to admit their failure to the counselor or they are ambivalent about making a permanent change. Careful inquiry by the counselor reveals which situation is the case.

The counselor should cover six basic points when speaking with the client again:

- Clarify the reasons for the missed appointment.
- Affirm the client and reinforce him or her for having entered the program.
- Express eagerness to see the client again.
- Briefly mention serious concerns that have emerged in treatment and express appreciation (when appropriate) that the client is exploring them.
- Express optimism about the prospects for change.
- Reschedule the appointment.

If no reasonable explanation (e.g., illness, lack of transportation) is offered for the missed appointment, the counselor can explore with the client whether the missed appointment might reflect any of the following:

- Uncertainty about whether the treatment is needed (e.g., "I don't really have a problem").
- Ambivalence about making a change.
- Frustration or anger about having to participate in treatment (particularly in clients who were mandated to enter the program).
- Embarrassment about a relapse. If client's absence was because of a slip, the counselor should be nonjudgmental and should encourage the client to come to a session clear headed and process the experience, noting that both the client and the counselor will learn from the discussion.

When a client returns to treatment after a missed session, the counselor should show appreciation.

Counselor's Response to Slips

If a client slips and continues to use episodically, making statements such as "I messed up," "I'm a failure," or "This isn't working," the counselor can commend the client on his or her honesty and convey the idea that occasional slips are common in the course of treatment; they do not mean that the treatment is not working or that the client is a failure:

C: *You may find it hard to stay abstinent. Slips are actually common occurrences and nothing to feel ashamed about. You were abstinent for about 3 weeks before the slip. That was a significant amount of time! What are some things you can do to remain abstinent and not slip?*

Goal of Abstinence From Marijuana

Marijuana Treatment Project participants were told that their counseling would focus on achieving abstinence. It was made clear, however, that individuals who wanted to reduce use would not be dropped automatically from the program. People working toward a moderation objective were encouraged to learn to be abstinent for several months. The rationale for this suggestion included two main points:

1. *Learning refusal skills during a period of abstinence develops many important strengths needed to become permanently abstinent.*
2. *A period of abstinence likely gives the client more information about what it is like not being intoxicated on an ongoing basis.*

When following the BMDC approach, the counselor explains that ambivalent feelings about accepting abstinence as a goal are common. He or she encourages the client to discuss these feelings and any slips that occur. In addition, clients whose initial goals were to reduce use may make abstinence their new goal later.

Handling Marijuana Use or Intoxication

Before beginning treatment, the client should be told to refrain from using any substances. This should be communicated in a nonpunitive way, with the counselor explaining that the client can benefit most from the sessions if he or she is not under the influence of marijuana or other substances. Clients also might receive a handout with this expectation highlighted.

If a client comes to a session intoxicated, the counselor can proceed in several ways. The counselor should determine during the check-in what the client's use pattern has been since the last session and make a clinical judgment about whether the session should be rescheduled. For example, if the client appears to be intoxicated (e.g., has difficulty concentrating on the content of the session, seems unusually tangential in speech pattern), the counselor should suggest that they reschedule. If the counselor reschedules because of the client's appearing intoxicated, the treatment program should find alternative transportation home so that the client does not drive. Anyone asked to leave a session is encouraged to return to the next session abstinent and to continue in treatment. If the client smoked marijuana shortly before the appointment, but the counselor determines that the client can participate meaningfully in the session, the session can proceed as planned.

The client should be given specific guidelines for handling the immediate aftermath of a using episode. He or she should be advised to get rid of the marijuana, leave the setting in which the using occurred, and call someone for help (a spouse, a friend, or the supporter identified in session 2). The client should be cautioned about the feelings of guilt and self-blame that often accompany a slip and warned not to allow such reactions to prompt further drug use. Sessions 4, 5, 6, and 7 and elective skill topic 1 provide specific guidelines on preventing and handling slips.

Marijuana Withdrawal

Some clients report withdrawal symptoms such as flulike symptoms, increased anxiety, or difficulty sleeping after they stop using marijuana. These symptoms usually are not severe, start 12 to 24 hours after the last use, and last less than 2 weeks. In most cases, withdrawal symptoms are manageable without medical intervention. Clients can be encouraged to use behavioral strategies such as relaxation techniques for anxiety or to decrease caffeine intake for insomnia. However, if a client either reports having severe withdrawal symptoms or anticipates having a difficult time

based on previous experience, the counselor can suggest that the client see a physician for assistance and request permission to discuss the problem with the client's primary care physician. In some cases, the client may show more severe problems with anxiety, depression, or cognitive functioning than normally expected from a withdrawal syndrome. In these circumstances, the counselor can suggest that the client see a psychiatrist for an assessment and possible assistance during and after the withdrawal period.

Use of Alcohol

Abstinence from alcohol should be determined on a client-by-client basis. The counselor might point out that some individuals find that overcoming marijuana dependence is more likely if they abstain from drinking alcohol. The client who is concerned about being tempted to substitute alcohol for marijuana should stop all use of alcohol. If a counselor determines that a client has begun to abuse other drugs or alcohol during this treatment approach, the client should be treated appropriately.

Clients With Special Needs

It is important to be sensitive to the special needs of clients. For example, clients with children may need flexible schedules or assistance with child care. Some clients may be cognitively impaired or function at a generally low cognitive level and need adaptations in the treatment approach or techniques that increase the likelihood of their absorbing the material. Strategies may include additional practice with new behavioral skills and repetition of key concepts. The counselor may minimize the use of long and complex sentences or condense the information from cognitive behavioral session handouts (forms in sessions 3–9) onto index cards for some clients. The client-centered aspects of MET allow the counselor to adapt the sessions to the client's needs.

Arranging for Additional or Followup Treatment

The counselor and client should address the need for additional care. For example, some clients with a substance use disorder have co-occurring mental disorders, most commonly depression. The counselor is encouraged to assess the presence and severity of other problems that might require attention. The counselor can explain that the client can continue to make progress after treatment ends because the client now has the skills and the ability to continue to improve and progress as these skills are used in new situations. If after a careful discussion of these issues, the client asks for a referral or information about further substance abuse treatment, the counselor can provide this information readily.

Summary

The counselor has a complex task that involves relationship building, teaching, supporting, encouraging, monitoring progress and setbacks, and recognizing signs that the client may be withdrawing from treatment or losing his or her motivation to change. The counselor views these common clinical problems as part of the treatment process that can lead to client growth and the strengthening of the therapeutic alliance.

SECTION IV.
GETTING STARTED: ASSESSMENT SESSION

This section guides counselors through the assessment session. It outlines strategies for assessing individuals who present for Brief Marijuana Dependence Counseling (BMDC) treatment. These people have been determined to be appropriate for treatment based on a brief telephone contact or an initial triage or evaluation appointment.

The BMDC assessment session focuses on building rapport with the client while assessing his or her marijuana use. This section includes diagnosis and assessment instruments. The assessment findings are used to complete the *Personal Feedback Report* (PFR), which the counselor reviews with the client in subsequent sessions. An accurate assessment provides data that can be used as

- A starting point for therapy
- Motivation and feedback for the client
- A measure of therapy outcomes over time.

Building Rapport

One of the most important aspects of treatment, especially during the assessment session, is building rapport; through expressions of warmth, support, and empathy, the counselor gets to know the client. Although the assessment session focuses primarily on gathering information, the rapport established during this session defines the client–counselor relationship for remaining sessions.

Assessing Marijuana Use

BMDC uses the criteria identified in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) (American Psychiatric Association 1994), to diagnose marijuana dependence (exhibit IV-I) and marijuana abuse (exhibit IV-2). These criteria help the counselor determine a client's level of substance involvement and the associated consequences, as well as appropriate level of treatment. These criteria also can be used in later sessions to measure treatment effectiveness.

The symptoms of substance dependence typically are assessed first; substance abuse is considered a less severe substance use disorder, and its symptoms are assessed only if the client does not meet the criteria for a diagnosis of substance dependence. For this reason, tolerance, withdrawal, and symptoms describing impaired control over use are not included in the diagnosis of substance abuse. However, it may be useful to complete the assessment of abuse criteria even if dependence has been diagnosed to learn more about the nature and extent of negative consequences that result from the dependent use pattern.

The guidelines presented here will help the counselor make a diagnosis of marijuana dependence or abuse. If the counselor does not have the credentials required for making a diagnosis, he or she must receive verification from a State-qualified individual.

Exhibit IV-1. DSM-IV Substance Dependence Criteria

1. Tolerance, as defined by either of the following:
   - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   - Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   - The characteristic withdrawal syndrome for the substance
   - The substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused by or exacerbated by the substance.

Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders,* Copyright 1994. American Psychiatric Association (1994).

Exhibit IV-2. DSM-IV Substance Abuse Criteria

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
2. Recurrent substance use in situations in which it is physically hazardous
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by the effects of the substance

Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders,* Copyright 1994. American Psychiatric Association (1994).

Overview of Assessment Session: Building Rapport and Assessing Marijuana Use

Total Time: 1 hour, 30 minutes (1 hour, 20 minutes for session; 10 minutes to prepare PFR)

Delivery Method: MET-focused individual therapy

Materials (all forms include instructions and are at the end of this section):

- *Sample Timeline Follow-Back Calendar* for past month (form AS1)
- *Timeline Follow-Back Grid* (form AS2)
- *Timeline Follow-Back Marijuana Use Summary Sheet* (form AS3)
- *Structured Clinical Interview for DSM-IV* (form AS4)
- *Marijuana Problem Scale* (form AS5)
- *Reasons for Quitting Questionnaire* (form AS6)
- *Self-Efficacy Questionnaire* (form AS7)
- *Personal Feedback Report* and percentage tables (form AS8)

Goals for This Session:

- To build rapport with the client, creating a nonthreatening therapeutic environment
- To collect and document baseline marijuana use information to monitor therapeutic outcomes

Session Outline:

1. Build rapport and give an overview of the assessment process
2. Conduct an overview assessment using open-ended and summary questions
3. Use the timeline follow-back (TLFB) method to assess marijuana use
   - Complete the *TLFB Calendar* (form AS1)
   - Complete the *TLFB Grid* (form AS2)
   - Complete the *TLFB Marijuana Use Summary Sheet* (form AS3)
4. Administer the *Structured Clinical Interview for DSM-IV* (form AS4)
   - Assess substance dependence
   - Assess substance abuse
5. Explain and ask client to complete the *Marijuana Problem Scale* (form AS5); evaluate consequences of marijuana use
6. Administer *Reasons for Quitting Questionnaire* (form AS6); evaluate reasons for seeking treatment
7. Explain and ask client to complete *Self-Efficacy Questionnaire* (form AS7); assess targets for intervention
8. Conclude the session
9. Prepare the PFR before session 1

Assessment Session Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor assesses the client's marijuana use while laying the foundation for a positive client–counselor relationship.

Build Rapport and Give an Overview of the Assessment Process

To build rapport and engage the client during the assessment session, the counselor informs the client about the sequence of events for this session and what to expect in the overall treatment approach. Introducing session topics, providing information, and responding to client concerns are the primary tasks during this part of the session. The counselor could begin the first session of BMDC with the following introduction:

Counselor (C): *Let's talk about what we'd like to accomplish in the assessment session. We need a clear description of your marijuana use—how much marijuana you use, how often you use it, and what types of problems marijuana might be causing you. I'll ask you detailed questions about your marijuana and other drug and alcohol use, and I'll also ask you questions about how marijuana use has affected your daily life.*

I'll summarize this information in the Personal Feedback Report *that I'll give you during our next session. We'll use the PFR to compare your marijuana consumption with national averages and to get an idea about how to set your treatment goals. The session will take about 1 hour and 20 minutes. Some questions may be difficult to answer and a real test of your memory; just do your best to be honest and patient! Remember that the information is confidential and is used only to help you accomplish your therapy goals.*

Conduct an Overview Assessment Using Open-Ended and Summary Questions

Most assessment tools, including a few presented later in the session, use closed-ended questions *(How many days in the past month did you smoke marijuana?)*, but the counselor starts the session by using open-ended questions to engage the client (*Tell me about your marijuana use pattern over the last month*) before transitioning to more detailed tasks. Open-ended questions allow the counselor to establish a dialog with the client and build rapport by

- Showing genuine interest
- Conveying a nonjudgmental and accepting attitude
- Demonstrating the ability to track accurately what the client is saying
- Expressing empathy with the client.

The dialog might go as follows:

C: *How did you hear about this program?*

Shirley (S): *I've seen the ads in the paper for several weeks. Originally my husband left one on the kitchen table for me.*

C: *You've worked with your husband to get here, and the two of you have given this a great deal of thought. Have you tried to quit on your own?*

S: *I try to quit almost every day, or at least I think about it. I'm going to be an elementary school teacher; in fact, I'm doing my student teaching now. I feel that quitting is the right thing to do—to be a good example to the kids. But nothing ever changes.*

C: *But you keep trying. What brings you here today?*

S: *Well, I know someday I will quit, and I've been looking at the ad for this program. I never thought anyone would offer treatment for pot smokers!*

C: *This was the opportunity you were waiting for. What would you like to see happen as a result of coming to treatment?*

S: *I guess I thought I'd get help on how to quit. But I realize that ultimately it's up to me, and it's way past time to do something.*

C: *You understand that it's your decision on what to do, but you also think that being here might help you. How confident are you at this point that you'll succeed?*

Use the TLFB Method To Assess Marijuana Use

The assessment or evaluation component of this session can be a powerful element of treatment. Marijuana Treatment Program (MTP) participants reported increased motivation after receiving feedback from assessment-related activities.

During the session the counselor and client complete several forms to assess the client's marijuana use. Quantity of marijuana use is difficult to measure because of varying potency levels and smoking methods (e.g., pipe, joint); therefore, frequency of use is the most reliable criterion for consumption measures. The TLFB method helps the counselor and client identify patterns and possible consequences of use (Sobell and Sobell 2000; Sobell et al. forthcoming). For instance, a person who uses heavily on weekends may be at risk of driving an automobile while high. A chronic, daily use pattern might indicate that an individual has developed cannabis dependence. In addition to providing a precise measure of marijuana consumption, the TLFB method can assess changes in a client's marijuana use and helps the counselor determine treatment effectiveness. The counselor begins by asking the client to estimate generally how many days and how many times a day he or she smoked marijuana in the past month:

C: *In the past month, about how many days did you smoke marijuana?* [Waits for client's response before asking the next question.] *In the past month, on a typical day when you smoked marijuana, about how many times per day did you smoke?*

Once the counselor has a general sense of the client's use, the formal TLFB assessment process begins. The counselor uses the following instruments to assess the pattern, severity, and nature of the client's marijuana use:

- *TLFB Calendar* for the past month (form AS1)
- *TLFB Grid* (form AS2)
- *TLFB Marijuana Use Summary Sheet* (form AS3).

The counselor uses the *TLFB Calendar* to help the client recall his or her marijuana use and the *TLFB Grid* to record summary information from the completed calendar. When completed, the

TLFB Marijuana Use Summary Sheet provides an overview of basic information about the client's marijuana use, alcohol consumption, and tobacco smoking. (The *TLFB Calendar* and *TLFB Marijuana Use Summary Sheet* procedures are modified from procedures developed by Sobell and Sobell [1992, 2000, 2003] and Sobell and colleagues [forthcoming]. Some administration guidelines are adapted from the Form 90 procedure developed by Miller [1996].)

Complete the TLFB Calendar

The counselor begins by developing a detailed history of daily marijuana use for a specified period, called the *assessment window*. This manual suggests an assessment window of 1 month. To arrive at a diagnosis of dependence or abuse, the DSM-IV advises that symptoms be present for 12 months. However, assessing symptoms for the last 12 months may tell little about the client's current use, especially if the client's use pattern has changed significantly over the year prior to entering treatment. (If the client had attempted to quit using or cut back usage in preparation for treatment, the counselor should ask the client to recall a period of usual marijuana use.) Understanding marijuana use at treatment entry is helpful for treatment planning and for motivating the client to change. The TLFB method uses memory aids (exhibit IV-3) to help the client recall his or her marijuana use. The counselor and client select a month to investigate. The counselor fills in the days on the *TLFB Calendar* (form AS1) and indicates which days in that particular month are holidays or other special days for the client (see exhibit IV-4 for a sample).

Exhibit IV-3. Key Events To Record on the Calendar

Atypical Events	Recurring Events	Discrete Events
• Holidays • Birthdays • Anniversaries • Parties • Medical appointments • Accidents • Court appearances • Beginning or termination of employment • Marital arguments • Vacations • Separations or reconciliations • Sporting events • Major news events • Concerts	• Paydays • Religious services • School or classes • Standing appointments • Child visitations • Meetings • Work schedule • Weekends	• Jail time • Hospitalizations • Illness • Treatment

The calendar is used as a memory aid. The counselor asks the client to recall daily consumption of marijuana by linking memories to salient life events. The counselor mentions recurring and atypical events to help the client recall his or her marijuana use. Recurring events (e.g., work schedule,

Exhibit IV-4. Sample Completed Calendar

December 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 Church/visit mom	2	3	4 ***Typical Pattern***	5 Payday	6	7
X X X	X X X	X X X	X X X	X X X	X X X X	X X X X
8 Church/visit mom	9	10	11	12	13	14 A Ohio
X X X	X X X	X X X	X X X	X X X	X	
15 A Ohio	16 Ohio (home)	17	18	19 Payday	20 Christmas party @ work	21
	X X	X X X	X X X	X X X	X X X X	X X X X
22 Church/visit mom	23 Day off	24 Day off Christmas Eve	25 A Christmas	26	27	28
X X X	X X X X	X		X X X	X X X X	X X X X
29 Church/visit mom	30	31 New Year's Eve party @ house				
X X X	X X X	X X X				

payday) provide a context for describing typical marijuana use patterns (e.g., client always buys marijuana on payday and smokes all day on days off). Atypical events (e.g., medical appointment, marital argument) provide anchor points for describing exceptions to a regular use pattern (e.g., client did not smoke on the day of a medical appointment; smoked more on the day of a marital argument). Discrete events (e.g., jail time, hospitalizations) help identify use and nonuse periods:

C: *I'd like to start by asking you questions about your marijuana use, other drug use, and drinking during the period from about a month ago until yesterday.* [Places the calendar in front of the client.] *We'll reconstruct this period by using notes on the calendar to help you remember things that have happened to you. Then we'll use these events to help you remember when you used marijuana on each day.*

After the counselor and client determine on which days the client smoked, they record the number of smoking episodes per day by breaking each calendar day into four quadrants. (As the client breaks down daily use into quadrants, it may be helpful for the counselor to have a card that lists the quadrants for the client to refer to.) The four boxes on each calendar day in exhibits IV-4 and IV-5 correspond to these following quadrants:

- Quadrant 1 = 6 a.m. to 12 noon (morning)
- Quadrant 2 = 12 noon to 6 p.m. (daytime)
- Quadrant 3 = 6 p.m. to midnight (evening)
- Quadrant 4 = 12 midnight to 6 a.m. (nighttime).

For instance, in the example in exhibit IV-5, the client smoked in the second and third quadrants on December 22, in all quadrants on December 23, and in the first quadrant on December 24. The counselor explains that this information reveals the context in which marijuana use occurs.

Exhibit IV-5. Using Quadrants To Determine Use Frequency

December 22				December 23				December 24			
Church/visit mom				Day off				Day off Christmas Eve			
	X	X		X	X	X	X	X			

The counselor records any other drug or alcohol use that occurred during the assessment window. By asking questions about alcohol and drug use, the counselor determines whether the client is substituting other drugs or alcohol on days when marijuana is not used.

Once the memorable events have been recorded, the counselor focuses on the client's longest span of invariant or unchanging behavior, such as abstinence, and determines whether a steady marijuana use pattern exists:

C: *Looking at the calendar and thinking about these events, what is the longest period you can remember when you went without smoking at all?*

If the client has had a reasonably consistent pattern of use from week to week, the counselor asks him or her to describe a typical week and to identify the weeks during the period that fit the steady pattern and record those weeks on the calendar:

C: *During this period when you were using marijuana, was your pattern of use similar from one week to the next? Although a person's marijuana use will vary from day to day, I'm wondering whether there was any consistency from week to week.*

The counselor starts with weekdays, beginning in one quadrant and moving through the week for that quadrant, the second quadrant, and so on:

C: *Could you describe a usual or typical week of marijuana use? Thinking about a typical week, starting with weekdays, Monday through Friday, did you normally use marijuana in the morning, between 6 a.m. and noon?*

This phrasing encourages the client to report use in the morning. The client points out variations in day-to-day use (e.g., *I smoke before I go to work on 2 mornings a week*). The counselor records variations on particular days. After constructing the morning quadrants, the counselor proceeds until all the appropriate quadrants have been checked to establish the weekday pattern. The

counselor then asks about weekend use. This exercise reveals the client's steady use pattern during the assessment window.

The counselor and client now turn to reconstructing the client's use on days when no pattern exists. If the client reports no consistent pattern, the entire assessment window must be constructed one day at a time.

For days not covered by pattern or abstinent days, the counselor focuses on days immediately before and after invariant periods (such as periods of abstinence and steady pattern use):

C: *What happened at this point? How did your marijuana use change?*

To help the client recall use, the counselor focuses on events that affect the availability of marijuana and the client's marijuana use (e.g., hospitalizations, family outings, work changes). The counselor pays close attention to inconsistencies in the client's descriptions of marijuana use and asks questions to ensure that the information is accurate.

Complete the TLFB Grid

The *TLFB Grid* (form AS2) is used to summarize and record calendar data and to monitor changes over time. The grid provides spaces for the counselor to total the days of use under various categories. When the information is presented on the grid, the counselor and client see use patterns emerge (e.g., the client usually smokes late at night or before work). Additional grids can be filled out in later sessions and compared with this baseline grid to monitor changes over time and help determine causes for slips or relapses.

Complete the TLFB Marijuana Use Summary Sheet

The counselor uses the *TLFB Marijuana Use Summary Sheet* (form AS3) to gather additional information about the client's marijuana consumption prior to entering treatment. The counselor asks questions that help the client think about and summarize his or her marijuana use, including use in hazardous situations (e.g., taking care of children, driving). The *TLFB Marijuana Use Summary Sheet* increases awareness of the frequency of using marijuana, other drugs, alcohol, and tobacco and often elicits concerns from the client. These stated concerns can increase motivation to change.

Administer the Structured Clinical Interview for DSM-IV

Several self-report scales assess substance dependence and substance abuse symptoms, but none assesses specifically for marijuana. Identification of cannabis use disorders is accomplished most reliably using a structured interview to assess diagnostic criteria. The *Structured Clinical Interview for DSM-IV* (SCID-IV) (form AS4) used in this manual has been adapted for clients who use marijuana (First et al. 1996). A typical structured interview starts with objective questions to obtain a brief history of the client's substance use and proceeds through a series of questions that assess for the presence of DSM-IV diagnostic criteria for dependence (questions 1 through 7) and abuse (questions 8 through 11). Each objective question can be followed by open-ended prompts to elicit information relevant to the symptom being assessed.

The counselor asks the client each SCID-IV question and circles the appropriate clinical rating for the response. If the counselor is convinced that a particular symptom is present, he or she should not allow a client's denial of the symptom to go unchallenged. In rare cases, an item may be rated as present even when the client steadfastly denies it. It is not necessary for the client to agree that the symptom is present. The counselor uses all sources of information, including the forms completed in the TLFB process, to determine the appropriate rating for the client in response to SCID-IV questions. In some cases, the counselor may need to explore discrepancies between the client's account and other sources of information. Form AS4 provides additional instructions for completing the SCID-IV.

Information for Assessing Cannabis Dependence Criteria

To administer the SCID-IV and assess for the presence of each symptom, it is important to understand the intent of substance use disorder criteria and the ways in which symptoms can be manifested in people who use marijuana.

Tolerance. Tolerance refers to needing more or higher quality marijuana to get high than when the client first began using it (DSM-IV symptom 1 in exhibit IV-1; SCID-IV question 6, *Have you found that you need to use a lot more or higher quality marijuana to get high than you did when you first started using it regularly?*). This symptom reflects the body's adaptation to or compensation for the chronic presence of marijuana, and it may predict the development of withdrawal symptoms if use continues. To determine tolerance level, the counselor asks the client to compare the current effects of marijuana with past effects.

According to DSM-IV, the client must use at least 50 percent more marijuana than when he or she first started using to meet the tolerance criterion, so it is important to ask the client to quantify how much more is used now to achieve the same effect compared with when he or she began to smoke regularly. The tolerance criterion can be met if the client reports markedly diminished effects from the same amount of marijuana that used to get him or her high.

Withdrawal. Withdrawal symptoms associated with cessation of cannabis use are another indication that the body has made physiological adaptations to the presence of cannabinoids and may motivate the person to continue using (DSM-IV symptom 2 in exhibit IV-1; SCID-IV question 7, *In the past month, have you had withdrawal symptoms? Have you felt sick when you cut down or stopped using? Or after not using for a few hours or more, have you smoked to keep from getting sick?*). Although a cannabis withdrawal syndrome is not described in DSM-IV, symptoms associated with marijuana cessation have been documented in several studies. Withdrawal symptoms can include

- Appetite disturbance
- Night sweats
- Nausea
- Restlessness
- Sleep disturbance (e.g., vivid dreams)
- Headaches
- Irritability

In general, when withdrawal symptoms occur, they are present for a short period (i.e., a few days to 2 weeks). It is not known to what extent these symptoms motivate continued use of marijuana or whether they play a clinically meaningful role in the process of modifying marijuana use. However, more than half the clients presenting for treatment report experiencing some withdrawal

symptoms or continuing to use marijuana to avoid withdrawal symptoms. The counselor asks the client about the occurrence of withdrawal symptoms when he or she has cut down or stopped using *and* whether he or she used marijuana to avoid withdrawal symptoms. If the client acknowledges either experience, then the criterion for this symptom is met.

Impaired control. To assess impaired control over use, the counselor asks whether the client often ended up smoking more than was intended and whether he or she sometimes smoked for a longer period than was intended (DSM-IV symptom 3 in exhibit IV-1; SCID-IV question 1, *In the past month, have you found that, when you started using marijuana, you ended up smoking much more of it than you were planning to?* or *Have you used it over a much longer period than you were planning to?*; an affirmative answer to either question should lead the counselor to inquire about specific instances and the circumstances leading to overuse). The repeated failure to terminate marijuana use as planned is evidence of impaired control.

Impaired control over marijuana use also is assessed by asking whether the client has made repeated unsuccessful attempts to quit or reduce use or has had a persistent desire to do so (DSM-IV symptom 4 in exhibit IV-1; SCID-IV question 2, *In the past month, have you tried to cut down or stop using marijuana?* or *Did you ever stop using altogether?*). Typically, these attempts include self-imposed rules or other strategies to avoid marijuana entirely or to limit the frequency of use. It is useful to ask specifically about the number of times the client has attempted to cut down during the period being assessed and whether these attempts were because of concern about the extent of use. Resumption of marijuana use after seeking professional help or joining a mutual-help group (e.g., Narcotics Anonymous) is evidence of lack of success. These experiences suggest impairment in control. If the client denies any attempts at reducing marijuana use, the counselor asks specifically whether he or she would like to stop or reduce use but has not done so for some reason. Evidence of impaired control includes the client's wanting to stop or reduce use but not making an attempt because he or she knew that the attempt would be unsuccessful.

Salience. An important aspect of dependence relates to the primacy of the substance in a person's life. The salience of marijuana is investigated by asking the client about how much time he or she spends obtaining it, using it, and recovering from its effects (DSM-IV symptom 5 in exhibit IV-1; SCID-IV question 3, *In the past month, did you spend a lot of time using marijuana or doing whatever you had to do to get it?*). The phrase "a lot of time" is not defined precisely, but it often becomes clear that marijuana-related activities occupy an excessive amount of time. For instance, if the client is intoxicated on marijuana most of the day, most days of the week, for a month or more, then salience is apparent. At other times, the counselor determines the appropriateness of the amount of time given to marijuana-related activities. If marijuana use is confined to recreational times of the day or week, this symptom may not be present.

Another determinant of the salience of marijuana can be when the client reports that he or she has given up or reduced involvement in important social, occupational, or recreational activities because of marijuana use (DSM-IV symptom 6 in exhibit IV-1; SCID-IV question 4, *In the past month, did you use marijuana so often that you used it instead of working or spending time on hobbies or with your family or friends?*; a yes response to this question indicates that marijuana use has a higher priority than activities such as work or spending time with friends or family, hobbies, or exercising.) This breakdown in the normal processes of social control is an indication of dependence on the drug.

The persistence of marijuana use despite knowledge that it causes or exacerbates psychological or physical problems is an indication of either the salience of the drug or impaired control over its use (DSM-IV symptom 7, exhibit IV-1; SCID-IV question 5, *Do you forget things or have trouble concentrating? Are you anxious or sad a lot? Has marijuana caused you physical problems such as difficulty breathing, many colds, or a chronic cough? Has it made a physical problem worse?*).

The counselor assesses whether marijuana use leads to problems with motivation, depression, anxiety, concentration, memory, or other psychological problems. Similarly, the client's awareness about the effect of marijuana use on breathing, chronic cough, or other physical conditions is ascertained. If the client acknowledges a relationship between marijuana use and any of these physical or psychological problems but continues to use anyway, marijuana use may have a higher priority than his or her health or the client may be unable to limit use effectively.

Diagnosing cannabis dependence. To complete the diagnosis, the counselor counts the number of dependence symptoms that are present, that is, questions 1 through 7 on the SCID-IV that receive a rating of 3. If three or more questions have a rating of 3, the client meets DSM-IV criteria for cannabis dependence. In general, the dependence syndrome occurs on a continuum, so more symptoms indicate greater severity of dependence. Even when the client does not meet the criteria fully, the counselor should discuss symptoms that signal the beginning of a potential disorder and the level of impairment associated with the symptoms.

Information for Assessing Cannabis Abuse Criteria

In the absence of cannabis dependence, the counselor assesses recurrent negative consequences associated with marijuana to diagnose cannabis abuse. The counselor inquires about missed days at school or work related to marijuana use and asks whether marijuana has affected the client's abilities at school or on the job (DSM-IV symptom 1 in exhibit IV-2; SCID-IV question 8, *In the past month, have you missed work or school because you were high or hung over? How often did this occur?*). It may be appropriate to ask whether marijuana has interfered with keeping the house clean or taking care of children.

Other examples of abuse are driving when feeling high or engaging in other dangerous activities when under the influence of marijuana (DSM-IV symptom 2 in exhibit IV-2; SCID-IV question 9, *In the past month, did you use marijuana in situations in which it might have been dangerous*?), experiencing legal problems (DMS-IV symptom 3 in exhibit IV-2; SCID-IV question 10, *Has your use of marijuana gotten you into trouble with the law in the past month*), and continuing use despite awareness that use causes problems with friends, family, or co-workers (DSM-IV symptom 4 in exhibit IV-2; SCID-IV question 11, *Has your use of marijuana caused you problems with other people, such as with family members, friends, or people at work? Have you gotten into physical fights or had bad arguments about your marijuana use?*).

Diagnosing cannabis abuse. For a cannabis abuse diagnosis, at least one of the symptoms described above must have occurred two or more times during the period being assessed. More information is available in First and colleagues (1996, 2000).

Explain and Ask Client To Complete Marijuana Problem Scale*; Evaluate Consequences of Marijuana Use*

The *Marijuana Problem Scale* (MPS) (form AS5), developed by Stephens and colleagues (1994*a*), is a self-report assessment that helps the client identify areas in his or her life affected by marijuana use. It contains 19 items that represent potential negative effects of marijuana on social relationships, self-esteem, motivation and productivity, work and finances, physical health, memory impairment, and legal problems. The items were chosen based on existing self-report drug abuse severity measures and on data from people who sought treatment for marijuana use.

Some questions on the MPS are similar to those in the SCID-IV. However, the MPS is a self-report instrument and the counselor should not base diagnostic decisions on the MPS alone. Clinical judgment is needed to make a diagnosis of cannabis abuse.

The counselor gives the form to the client and instructs the client to take a few moments to respond to each item by indicating whether he or she experienced a particular problem related to marijuana use in the past month. After reading each question, the client circles the corresponding number on the questionnaire:

Not a problem (0) A minor problem (1) A serious problem (2).

After answering all the questions, the client gives the form back to the counselor who counts the number of items identified as either minor or serious problems. Higher scores generally indicate more serious problems with marijuana. However, it is important to review the specific problem items with clients because the nature of the problems reported may be more important than the total score. For instance, although nearly all people who use marijuana and seek treatment report feeling bad about their use, a smaller number will indicate serious problems with friends, family, work, or finances. Exhibit VII-1 in section VII presents the frequency of problems reported by MTP participants.

The counselor keeps the form and uses the information to complete the client's PFR, which is discussed in the next session.

Administer Reasons for Quitting Questionnaire*; Evaluate Reasons for Seeking Treatment*

The *Reasons for Quitting Questionnaire* (form AS6) is based on earlier work with tobacco cessation and has been modified based on initial results with people who use marijuana and seek treatment (McBride et al. 1994). The 26 items assess reasons for quitting marijuana in the following broad categories: health concerns, desire for self-control, and social and legal influences. The counselor gives the client the form and asks him or her to take a few moments to indicate the degree to which each reason applies to him or her using a 5-point scale:

Not at all (0) A little bit (1) Moderately (2) Quite a bit (3) Very much (4).

The counselor reviews the items that have been circled 2, 3, or 4. These responses represent the client's motivation for change. The items identified are used in the PFR. Reviewing the items that the client endorses stimulates discussion and elicits self-motivational statements during therapy. Exhibit VII-1 presents the most common marijuana-related problems reported by MTP participants.

The counselor keeps the form and uses the information to complete the client's PFR, which is discussed in the next session.

Explain and Ask Client To Complete Self-Efficacy Questionnaire*; Assess Targets for Intervention*

The *Self-Efficacy Questionnaire* (form AS7), based on the Situational Confidence Questionnaire (Annis 1988), is a measure on which clients rate their ability to resist the temptation to smoke marijuana in a variety of different situations. The rating scale has a range of 1 (not at all confident) to 7 (extremely confident). The counselor asks the client to take a few moments to rate 20 statements about situations that might create a temptation to smoke marijuana.

When the form is completed, the client returns it to the counselor who records in the PFR all items coded 1 to 3 (low confidence to resist marijuana).

Conclude the Session

To conclude the session, the counselor explains that he or she will use the information from all the forms to complete the client's PFR, which they will review during the next session. The counselor asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties.

Prepare the PFR Before Session 1

The PFR is a therapeutic tool used by the counselor to summarize the results obtained during assessment session. The goal of assessment feedback is to point out discrepancies between the client's current behavior and important personal goals identified by the client.

For the next session with the client, the counselor prepares the PFR by compiling the pertinent information from the TLFB process and the SCID-IV. Information also is gathered from the questionnaires completed by the client: *Marijuana Problem Scale, Reasons for Quitting Questionnaire,* and *Self-Efficacy Questionnaire.* All the information from these forms is consolidated on the PFR by the counselor. Instructions for preparing the PFR are included in form AS8.

Forms for Assessment Session

During the assessment session the counselor and client review or complete eight forms. These forms and instructions for completing them are provided on the remaining pages in this section.

Sample Timeline Follow-Back Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Timeline Follow-Back Grid

Start date: ___/___/___ *End date: ___/___/___*

	# of days used from 6 a.m.-12 noon	# of days used from 12 noon-6 p.m.	# of days used from 6 p.m.-12 mid	# of days used from 12 mid-6 a.m.	# of days used marijuana	# of days used alcohol	# of days used other drugs	# of days used any substance in the week
Week 1								
Week 2								
Week 3								
Week 4								
Total (for PFR)								

Timeline Follow-Back Marijuana Use Summary Sheet

(***To be completed after the calendar data have been collected.***)
I would like to ask you a few more questions about your marijuana and alcohol use.

1. During the past month, from _____to _____, on average, how much marijuana **per week** do you think you used in ounces?
   Probe by asking the participant how many ounces of marijuana he or she buys (or receives) per week. If the client seems uncertain about level of use, the counselor helps him or her approximate by using the following types of probes: "Would you say it was more like 1/8 ounce or closer to 1 ounce per week?" The counselor continues until the client seems comfortable with the estimate and says, "So, you think it was closer to an ounce. Was it just an ounce, a little more than that, or a little less?"
   _____<1/16 _____1/16 _____1/8 _____1/4 ____3/8
   _____1/2 _____5/8 _____3/4 _____7/8 _____1 oz.

2. During the past month, when you smoked, how many average-sized joints/pipes/blunts, do you think you smoked per day?
   ____ joints, pipes, or blunts per day

3. During the past month, when you smoked, how many hours did you feel high on those days?
   ____ hours

4. During the past month, on average, how many times a day did you get high?
   ____ times

5. During the past month, did you use marijuana 1 hour **before** the following activities? If yes, would you say (*read coding options to client*)?
   (1) less than weekly (2) weekly (3) less than daily (4) daily or almost daily
   ____5a. Driving a vehicle
   ____5b. Taking care of children
   ____5c. Operating dangerous equipment or heavy machinery
   ____5d. Working on a paid job

6. During the past month, how many standard drinks did you have on a typical day?
   One standard drink is a 12-ounce can or bottle of beer, a 5-ounce glass of wine, or a 1.5-ounce shot of hard liquor straight or in a mixed drink.
   ____ drinks per drinking day

7. During the past month, did you have six or more drinks in a single day?
   If yes, would you say (*read coding options to participant*)?
   (1) less than weekly (2) weekly (3) less than daily (4) daily or almost daily

8. During the past month, how many tobacco cigarettes did you smoke on a typical day?
   (0) none (1) less than 10 (2) About 1/2 pack (3) About 1 pack (4) More than a pack

Structured Clinical Interview for DSM-IV[1]

(Non-Alcohol Substance Use Disorders Module Modified for Marijuana Use, Past Month)

How old were you when you first started smoking marijuana regularly (i.e., 3 or more times a week)? ____

age of onset of regular use

How old were you when your marijuana use began to cause you problems? ____

age of problem use

Current Marijuana Dependence

Now I am going to ask you several questions about your marijuana use for the past month, that is since _____ .

(*give anchor date*)

Current marijuana dependence is characterized by a maladaptive pattern of marijuana use leading to clinically significant impairment or distress, as manifested by three or more of the following occurring during the assessment period. The counselor circles the appropriate clinical rating based on the chart below.

Interview Questions	Clinical Rating	DSM-IV Dependence Criteria
1. In the past month, have you often found that, when you started using marijuana, you ended up using much more than you were planning to? *If no:* Have you used it over a much longer period than you were planning to?	**? 1 2 3**	*3. Marijuana often is taken in larger amounts or over a longer period than was intended.*

Clinical Rating

? = Could not determine based on information provided.

1 = Absent or false; the symptom described in the criterion clearly is absent or the criterion statement clearly is false.

2 = Subthreshold; the threshold for the criterion is almost, but not quite, met.

3 = Threshold or true; the threshold for the criterion is met or the criterion statement is true.

[1]Source: First et al. 1996.

Structured Clinical Interview for DSM-IV (continued)

(Non-Alcohol Substance Use Disorders Module Modified for Marijuana Use, Past Month)

Interview Questions	Clinical Rating	DSM-IV Dependence Criteria
2. In the past month, have you tried to cut down or stop using marijuana? *If yes:* In the past month, did you ever stop using marijuana? (How many times did you try to cut down or stop?) *If no:* Did you have a desire to stop or cut down? *If yes:* Is this something you worry about?	? 1 2 3	*4. There is a persistent desire or one or more unsuccessful efforts to cut down or control marijuana use.*
3. In the past month, did you spend a lot of time using marijuana or doing whatever you had to do to get it? Did it take you a long time to get back to normal? (How much time? As long as several hours?)	? 1 2 3	*5. A great deal of time is spent in activities necessary to obtain marijuana, use marijuana, or recover from its effects.*
4. In the past month, did you use marijuana so often that you used it instead of working or spending time on hobbies or with your family or friends?	? 1 2 3	*6. Important social, occupational, or recreational activities are given up or reduced because of marijuana use.*
5. Do you forget things? Do you have trouble concentrating? Are you anxious or sad a lot? Do you think this has anything to do with marijuana? Has marijuana caused you physical problems such as difficulty breathing, many colds, or a chronic cough or made a physical problem worse? *If yes to either:* In the past month, did you keep on using marijuana anyway?	? 1 2 3	*7. Continued marijuana use despite knowledge of having a persistent or recurrent psychological or physical problem that is likely to have been caused or exacerbated by the use of the marijuana.*

Clinical Rating

? = Could not determine based on information provided.

1 = Absent or false; the symptom described in the criterion clearly is absent or the criterion statement clearly is false.

2 = Subthreshold; the threshold for the criterion is almost, but not quite, met.

3 = Threshold or true; the threshold for the criterion is met or the criterion statement is true.

Structured Clinical Interview for DSM-IV (continued)

(Non-Alcohol Substance Use Disorders Module Modified for Marijuana Use, Past Month)

Interview Questions	Clinical Rating	DSM-IV Dependence Criteria
6. Have you found that you need to use a lot more or higher quality marijuana to get high than you did when you first started using it regularly (e.g., three or more times a week)? *If yes:* How much more? *If no:* Do you find that, when you use the same amount, it affects you much less than it did before?	**? 1 2 3**	*1. Tolerance, as defined by either of the following:* *(a) A need for markedly increased amounts of marijuana (at least 50% increase) to achieve intoxication or desired effect* *or* *(b) Markedly diminished effect with continued use of the same amount of marijuana.*
7. In the past month, have you had withdrawal symptoms, that is, felt sick when you cut down or stopped using? *If yes:* What symptoms did you have? *If no:* After not using marijuana for a few hours or more, have you often used it to keep yourself from getting sick (withdrawal)?	**? 1 2 3**	*2. Withdrawal, as manifested by either of the following:* *(a) The characteristic withdrawal syndrome for marijuana, e.g., appetite disturbance, sleep disturbance (vivid dreams), night sweats, headaches, irritability, restlessness* *or* *(b) Marijuana or a closely related substance is taken to relieve or avoid withdrawal symptoms.*
Record the total number of items (1–7) coded 3.	*Number of dependence criteria met:* _____	*If three or more items are coded as 3, the client meets the DSM-IV diagnosis of current marijuana dependence.*

Clinical Rating

? = Could not determine based on information provided.

1 = Absent or false; the symptom described in the criterion clearly is absent or the criterion statement clearly is false.

2 = Subthreshold; the threshold for the criterion is almost, but not quite, met.

3 = Threshold or true; the threshold for the criterion is met or the criterion statement is true.

Structured Clinical Interview for DSM-IV (continued)

(Non-Alcohol Substance Use Disorders Module Modified for Marijuana Use, Past Month)

Current Marijuana Abuse

Now I am going to ask you a few more questions about your marijuana use for the past month, that is, since _____ .
(*give anchor date*)

Current marijuana abuse is characterized by a maladaptive pattern of marijuana use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring during the assessment period.

Interview Questions	Clinical Rating	DSM-IV Abuse Criteria
8. In the past month, have you missed work or school because you were high or hung over? Have you done a bad job at work or failed courses because of your marijuana use? *If no:* Have you not kept your house clean or not taken proper care of your children because of your use of marijuana? *If yes:* How often did this occur?	**? 1 2 3**	*1. Recurrent (two or more times) marijuana use resulting in a failure to fulfill major obligations at work, school, or home (e.g., repeated absences or poor work performance related to marijuana use; marijuana-related absences, suspensions, or expulsions from school; neglect of household or children).*
9. In the past month, did you use marijuana in a situation in which it might have been dangerous? (Did you drive while you were high?) *If yes:* How often did this occur?	**? 1 2 3**	*2. Recurrent (two or more times) marijuana use in situations in which it is physically hazardous (e.g., driving a car; operating dangerous equipment like a lawnmower, chain saw, stove, gun, or tractor; or skiing, swimming, biking or taking care of children when impaired by marijuana).*

Clinical Rating

? = Could not determine based on information provided.

1 = Absent or false; the symptom described in the criterion clearly is absent or the criterion statement clearly is false.

2 = Subthreshold; the threshold for the criterion is almost, but not quite, met.

3 = Threshold or true; the threshold for the criterion is met or the criterion statement is true.

Structured Clinical Interview for DSM-IV (continued)

(Non-Alcohol Substance Use Disorders Module Modified for Marijuana Use, Past Month)

Interview Questions	Clinical Rating	DSM-IV Abuse Criteria
10. Has your use of marijuana gotten you into trouble with the law in the past month? *If yes:* How often did this occur?	**? 1 2 3**	*3. Recurrent (two or more times) marijuana-related legal problems (e.g., arrests for marijuana-related disorderly conduct).*
11. Has your use of marijuana caused you problems with other people, such as with family members, friends, or people at work? Have you gotten into physical fights or had bad arguments about your marijuana use? *If yes:* In the past month, did you keep on using marijuana anyway?	**? 1 2 3**	*4. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of marijuana (e.g., arguments with spouse, physical fights).*
Record the total number of items (8–11) coded 3.	*Number of abuse criteria met* _____	*If one or more items (8–11) are coded as 3, the client meets the DSM-IV diagnosis of current marijuana abuse.*

Clinical Rating

? = Could not determine based on information provided.

1 = Absent or false; the symptom described in the criterion clearly is absent or the criterion statement clearly is false.

2 = Subthreshold; the threshold for the criterion is almost, but not quite, met.

3 = Threshold or true; the threshold for the criterion is met or the criterion statement is true.

Marijuana Problem Scale

Following are different types of problems you may have experienced as a result of smoking marijuana. Please circle the number that indicates whether each item has been a problem for you in the past month.

Has marijuana use caused you...	No Problem	Minor Problem	Serious Problem
1. Problems between you and your partner	0	1	2
2. Problems in your family	0	1	2
3. To neglect your family	0	1	2
4. Problems between you and your friends	0	1	2
5. To miss days at work or miss classes	0	1	2
6. To lose a job	0	1	2
7. To have lower productivity	0	1	2
8. Medical problems	0	1	2
9. Withdrawal symptoms	0	1	2
10. Blackouts or flashbacks	0	1	2
11. Memory loss	0	1	2
12. Difficulty sleeping	0	1	2
13. Financial difficulties	0	1	2
14. Legal problems	0	1	2
15. To have lower energy level	0	1	2
16. To feel bad about your use	0	1	2
17. Lowered self-esteem	0	1	2
18. To procrastinate	0	1	2
19. To lack self-confidence	0	1	2

Marijuana Problem Scale (continued)

Marijuana Problem Scale Scoring Instructions

To obtain the Marijuana Problem Scale *(MPS) Score, add the number of items reported as either a minor problem or serious problem. This score is used in the* Personal Feedback Report *(form AS8) and compared with the scores in table C at the end of the instructions for creating the PFR.*

Items circled as 1 or 2 by the client should be checked on part II of the Personal Feedback Report *(form AS8).*

For Office Use

MPS Score: _____

Reasons for Quitting Questionnaire

People who want to stop smoking marijuana may have several reasons for quitting. I am interested in finding out your reasons for wanting to quit.

There are no right or wrong reasons. Any reason is a good one. Below is a list of reasons that a person may have. Please read each statement and circle the number that best describes how much this reason applies to you at this time.

I want to quit smoking marijuana at this time...	Not at All	A Little Bit	Moder-ately	Quite a Bit	Very Much
1. To show myself that I can quit if I want to	0	1	2	3	4
2. Because I will like myself better if I quit	0	1	2	3	4
3. Because I won't have to leave social functions or other people's houses to smoke	0	1	2	3	4
4. So that I can feel in control of my life	0	1	2	3	4
5. Because my family and friends will stop nagging me if I quit	0	1	2	3	4
6. To get praise from people I'm close to	0	1	2	3	4
7. Because smoking marijuana does not fit in with my self-image	0	1	2	3	4
8. Because smoking marijuana is becoming less socially acceptable	0	1	2	3	4
9. Because someone has told me to quit or else	0	1	2	3	4
10. Because I will receive a special gift if I quit	0	1	2	3	4
11. Because of potential health problems	0	1	2	3	4
12. Because people I am close to will be upset if I don't quit	0	1	2	3	4
13. So that I can get more things done	0	1	2	3	4
14. Because I have noticed that smoking marijuana is hurting my health	0	1	2	3	4
15. Because I want to save the money I spend on marijuana	0	1	2	3	4

Reasons for Quitting Questionnaire (continued)

I want to quit smoking marijuana at this time...	Not at All	A Little Bit	Moder-ately	Quite a Bit	Very Much
16. To prove that I'm not addicted to marijuana	0	1	2	3	4
17. Because there is a drug-testing policy at work	0	1	2	3	4
18. Because I know others with health problems caused by smoking marijuana	0	1	2	3	4
19. Because I am concerned that smoking marijuana will shorten my life	0	1	2	3	4
20. Because of legal problems related to marijuana	0	1	2	3	4
21. Because I don't want to be a bad example for children	0	1	2	3	4
22. Because I want to have more energy	0	1	2	3	4
23. So that my hair and clothes won't smell like marijuana	0	1	2	3	4
24. So that I won't burn holes in clothes or furniture	0	1	2	3	4
25. Because my memory will improve	0	1	2	3	4
26. So that I will be able to think more clearly	0	1	2	3	4

Use the spaces below to list the three most important reasons for wanting to stop smoking marijuana. If any of the statements above are among your most important reasons, list them in the spaces below. Otherwise, write your own reasons.

27. My three most important reasons, in order of importance, for wanting to quit smoking marijuana are:

    1. _____

    2. _____

    3. _____

Reasons for Quitting Questionnaire (continued)

Please check the box that applies to you.

- ❒ I have not yet quit smoking marijuana (answer only 28).
- ❒ I have stopped smoking marijuana already (answer only 29).

28. If you have not yet quit smoking marijuana, circle the number that indicates how ready you are RIGHT NOW to stop smoking marijuana.

0%--------20%----------40%----------60%----------80%----------100%
ready to quit — ready to quit

29. If you have stopped smoking marijuana already, circle the number that indicates how ready you are RIGHT NOW to remain abstinent.

0%--------20%----------40%----------60%----------80%----------100%
ready to remain abstinent — ready to remain abstinent

Reasons for Quitting Questionnaire Scoring Instructions

For a total Reasons for Quitting *(RFQ) Score, add the number of items the client reported as a reason to quit smoking marijuana. Count only those responses coded as 2, 3, or 4 (moderately, quite a bit, or very much). Include any open-ended items in question 27 that are not in the list.*

Items circled as 2, 3, or 4 by the client are his or her most relevant reasons for quitting marijuana. These items should be checked on part III of the Personal Feedback Report *(form AS8).*

For Office Use

RFQ Score: _____

Self-Efficacy Questionnaire[2]

Please circle how confident you are that you could **resist** the temptation to smoke marijuana in the following situations.

How confident are you that you could resist the temptation to smoke marijuana if you were...	Not at all Confident						Extremely Confident
1. Doing monotonous work	1	2	3	4	5	6	7
2. Wanting to feel more confident	1	2	3	4	5	6	7
3. Vacationing	1	2	3	4	5	6	7
4. Seeing someone else smoking marijuana and enjoying it	1	2	3	4	5	6	7
5. Feeling depressed or worried	1	2	3	4	5	6	7
6. Drinking alcohol	1	2	3	4	5	6	7
7. Feeling like celebrating good news or an accomplishment	1	2	3	4	5	6	7
8. Feeling frustrated	1	2	3	4	5	6	7
9. Wanting to feel better about yourself	1	2	3	4	5	6	7
10. Feeling angry about something or someone	1	2	3	4	5	6	7
11. Enjoying a pleasant social situation	1	2	3	4	5	6	7
12. Having time to yourself, free of responsibilities	1	2	3	4	5	6	7
13. Using other drugs recreationally	1	2	3	4	5	6	7
14. Being at a party with people who are smoking marijuana	1	2	3	4	5	6	7
15. Feeling embarrassed	1	2	3	4	5	6	7
16. Being with a spouse or close friend who is smoking marijuana	1	2	3	4	5	6	7
17. Being in an uncomfortable social situation	1	2	3	4	5	6	7
18. Being offered marijuana by someone	1	2	3	4	5	6	7
19. Being bored, with nothing to do	1	2	3	4	5	6	7
20. Feeling stressed out and needing to calm down	1	2	3	4	5	6	7

[2]Sources: Stephens et al. 1993*a*, 1995.

Self-Efficacy Questionnaire (continued)

Self-Efficacy Questionnaire Scoring Instructions

To obtain the Self-Efficacy *(SE) Score, add the numbers circled for each item and divide by the total number answered (the denominator should be 20 unless an item was skipped).*

Items circled as 1, 2, or 3 indicate that the particular situations would be more difficult to resist and would affect the client's ability to remain abstinent. These items should be checked on part IV of the Personal Feedback Report *(form AS8).*

For Office Use

SE Score: _____

Instructions for Creating the Personal Feedback Report

The items in **bold font** are the statements to be filled in on the PFR. The means of obtaining the information is in *italics*.

The assessments to be completed (by interview or self-report) by the client include

- *TLFB Grid* (summarized from the calendar) (form AS2)
- *TLFB Marijuana Use Summary Sheet* (form AS3)
- SCID-IV (form AS4)
- *Marijuana Problem Scale* (form AS5)
- *Reasons for Quitting Questionnaire (*form AS6)
- *Self-Efficacy Questionnaire (*form AS7).

Reference tables can be found at the end of these instructions and include

- Table A. Marijuana Use for Americans Ages 12 and Older
- Table B. Marijuana Use for Treatment-Seeking Adults
- Table C. Marijuana Consequences
- Table D. Confidence in Avoiding Use.

Part I. Your Marijuana Consumption

You reported that you have been smoking regularly for ____ years.

Calculate using age of onset of regular use from SCID-IV (form AS4).

In the past month, you smoked marijuana on ____ days.

Insert total number of days used marijuana from TLFB Grid *(form AS2).*

You said you smoked ____ joints/pipes/blunts per day during that same period.

Insert number from question 2 on TLFB Marijuana Use Summary Sheet *(form AS3).*

Relative to other Americans, this places you in the ____th percentile. This means that ____ percent of other Americans smoke less than you do.

Use table A to determine the percentile based on the number of days smoked in the past 30 days. Look up the number of days used, and record the percentile. Use the same number in the Personal Feedback Report *to illustrate the percentage of other Americans who smoke less than the client does.*

Relative to other adults who have sought counseling for their marijuana use, you fall in the ____th percentile. This means that you smoke more marijuana than ____ percent of individuals seeking marijuana treatment.

Use table B to determine the percentile based on the number of days smoked in the past 30 days. See above.

Instructions for Creating the Personal Feedback Report (continued)

Part II. Your Problems Related to Marijuana

***For these items, use* Marijuana Problem Scale (*form AS5*).**

You indicated that your marijuana use causes a number of problems for you, including:
On the Personal Feedback Report, *check off the items indicated as a minor or serious problem.*

You identified ____ problems caused by your marijuana use.
Insert the MPS Score.

This places you in the ____th percentile relative to other adults seeking marijuana treatment. This means that you experience more problems than ____ percent of people seeking treatment for their marijuana use.
Look up the MPS Score in table C and record the percentile. Place the same number in both blanks.

For these items, use SCID-IV (form AS4)

You also indicated that
On the Personal Feedback Report*, check off any criteria coded as a 3 on the SCID-IV.*

As you reflect on the consequences of smoking marijuana and how they affect your life, what else might you add?
Record any other comments or reflections the client states.

Part III. Your Reasons for Quitting Marijuana

***For these items, use* Reasons for Quitting Questionnaire (*form AS6*).**

You listed the following personal reasons for quitting marijuana and said that they applied to you moderately, quite a bit, or very much at this time.
On the Personal Feedback Report*, check off items indicated moderately, quite a bit, or very much.*

You listed these reasons because they have personal significance for you. Do you have any other important reasons for quitting that you would like to add?
List the three most important reasons the client indicates for wanting to quit (question 27). Record any other reasons the client mentions.

Your number of personal reasons for quitting marijuana is _____.
Insert the RFQ Score.

Part IV. Difficult Situations for Maintaining Abstinence

***For these items, use* Self-Efficacy Questionnaire (*form AS7*).**

You predicted your most difficult situations for maintaining abstinence from marijuana. These high-risk situations include
Check off items reported as 1, 2, or 3.
As you think about highly tempting situations, are there situations that you'd like to add?

Instructions for Creating the Personal Feedback Report (continued)

Record other comments or tempting situations the client adds.

Your responses indicate how confident you are that you could avoid smoking marijuana in these situations and resulted in an SE Score of ____.
Insert SE Score.

This places you in the ____th percentile compared with other adults who have sought counseling to help them stop smoking marijuana.
Match the SE Score with the scores on table D, and record the percentile.

This means that you are more confident that you could resist the temptation to smoke marijuana than ____ percent of treatment-seeking individuals.
Place the same number in this blank.

Table A. Marijuana Use for Americans Ages 12 and Older (Past 30 Days)

# Days Used in the Past 30 Days	Percentile Ranking
1 day	94
2-3 days	95
4-7 days	96
8-14 days	97
15-24 days	98
>25 days	99

Source: Substance Abuse and Mental Health Services Administration 2001.

Table B. Marijuana Use for Treatment-Seeking Adults (Past 30 Days)

# Days Used in the Past 30 Days	Rounded Percentile Ranking	# Days Used in the Past 30 Days	Rounded Percentile Ranking
0	0	16	11
1	0	17	12
2	1	18	13
3	1	19	14
4	2	20	19
5	2	21	20
6	2	22	21
7	3	23	26
8	4	24	27
9	4	25	32
10	5	26	34
11	6	27	44
12	7	28	53
13	8	29	64
14	8	30	100
15	11		

Sources: Stephens et al. 1994*b*, 2000; Vendetti et al. 2002.

Instructions for Creating the Personal Feedback Report (continued)

Table C. Marijuana Consequences			
Marijuana Problem Score	Rounded Percentile Ranking	Marijuana Problem Score	Rounded Percentile Ranking
0	0	10	57
1	1	11	68
2	3	12	77
3	5	13	85
4	8	14	91
5	11	15	95
6	16	16	98
7	23	17	99
8	32	18	100
9	44	19	100

Sources: Stephens et al. 2000; Vendetti et al. 2002.

Table D. Confidence in Avoiding Use			
Self-Efficacy Score	Rounded Percentile Ranking	Self-Efficacy Score	Rounded Percentile Ranking
1.00-1.25	2	2.74-2.79	21
1.28-1.35	3	2.80-2.80	22
1.37-1.50	4	2.83-2.84	23
1.53-1.58	5	2.85-2.89	24
1.60-1.70	6	2.89-2.94	25
1.75-1.85	7	2.95-2.95	26
1.90-2.00	8	3.00-3.00	27
2.05-2.05	9	3.05-3.05	28
2.10-2.15	10	3.06-3.11	29
2.20-2.22	11	3.15-3.16	30
2.25-2.32	12	3.17-3.20	31
2.33-2.37	13	3.21-3.21	32
2.39-2.40	14	3.22-3.25	33
2.41-2.44	15	3.26-3.28	34
2.45-2.47	16	3.30-3.33	35
2.50-2.58	17	3.35-3.35	36
2.60-2.60	18	3.37-3.39	37
2.61-2.65	19	3.40-3.40	38
2.67-2.72	20	3.42-3.45	39

Instructions for Creating the Personal Feedback Report (continued)

Table D. Confidence in Avoiding Use (continued)			
Self-Efficacy Score	**Rounded Percentile Ranking**	**Self-Efficacy Score**	**Rounded Percentile Ranking**
3.47-3.47	40	4.47-4.55	72
3.50-3.50	41	4.56-4.58	73
3.53-3.53	42	4.60-4.65	74
3.55-3.56	43	4.67-4.74	75
3.58-3.58	44	4.75-4.78	76
3.60-3.60	45	4.79-4.80	77
3.61-3.63	46	4.83-4.85	78
3.65-3.68	47	4.89-4.90	79
3.70-3.70	48	4.94-4.95	80
3.72-3.76	49	5.00-5.00	81
3.78-3.79	50	5.05-5.06	82
3.80-3.80	51	5.11-5.16	83
3.83-3.84	52	5.17-5.21	84
3.85-3.89	54	5.22-5.28	85
3.90-3.90	55	5.30-5.33	86
3.94-3.95	56	5.37-5.42	87
4.00-4.05	58	5.44-5.47	88
4.05-4.05	59	5.50-5.56	89
4.06-4.06	60	5.58-5.63	90
4.10-4.11	61	5.65-5.70	91
4.12-4.16	62	5.72-5.78	92
4.17-4.20	63	5.79-5.84	93
4.21-4.22	64	5.89-6.05	94
4.25-4.26	65	6.06-6.16	95
4.28-4.28	66	6.17-6.30	96
4.30-4.32	67	6.33-6.55	97
4.33-4.35	68	6.56-6.75	98
4.39-4.40	69	6.83-6.95	99
4.42-4.42	70	7.00-7.00	100
4.44-4.45	71		

Sources: Stephens et al. 1994*b*, 2000; Vendetti et al. 2002.

Personal Feedback Report

This report summarizes information about your marijuana use. The information may be useful in developing strategies to resist marijuana.

Part I. Your Marijuana Consumption

You reported that you have been smoking regularly for ____ years.

In the past month, you smoked marijuana on ____ days.

You said you smoked ____ joints/pipes/blunts per day during that same period.

Relative to other Americans, this places you in the ____th percentile. This means that ____ percent of other Americans smoke less than you do.

Relative to adults who have sought counseling for their marijuana use, you fall in the ____th percentile. This means that you smoke more marijuana than ____ percent of individuals seeking marijuana treatment.

Part II. Your Problems Related to Marijuana

You indicated that your marijuana use causes a number of problems for you, including:

_____ Problems between you and your partner

_____ Problems in your family

_____ To neglect your family

_____ Problems between you and your friends

_____ To miss days at work or miss classes

_____ To lose a job

_____ To have lower productivity

_____ Medical problems

_____ Withdrawal symptoms

_____ Blackouts or flashbacks

_____ Memory loss

_____ Difficulty sleeping

_____ Financial difficulties

_____ Legal problems

_____ To have lower energy level

_____ To feel bad about your use

_____ Lowered self-esteem

_____ To procrastinate

_____ To lack self-confidence

Personal Feedback Report (continued)

You identified ____ problems caused by your marijuana use.

This places you in the ____th percentile relative to other adults seeking marijuana treatment. This means that you experience more problems than ____ percent of people seeking treatment for their marijuana use.

You also indicated that

_____ You often have found that when you start using marijuana, you end up smoking much more of it than you were planning to. (SCID-IV, question 1)

_____ You frequently thought about or tried unsuccessfully to cut down or control your use of marijuana. (SCID-IV, question 2)

_____ You spent a great deal of time trying to get marijuana, smoking it, or recovering from its effects. (SCID-IV, question 3)

_____ You sometimes gave up or did not participate in important occupational, social, or recreational activities because you were using marijuana. (SCID-IV, question 4)

_____ You continued using marijuana despite knowing that it was contributing to social, psychological, or physical problems in your life. (SCID-IV, question 5)

_____ You needed to smoke more marijuana than you had smoked in the past to get the same effect. (SCID-IV, question 6)

_____ You noticed that you were not getting as high as you used to when you smoked the same amount of marijuana. (SCID-IV, question 6)

_____ You experienced withdrawal symptoms when you tried to stop using marijuana (e.g., difficulty sleeping, irritability, excessive perspiration). (SCID-IV, question 7)

_____ You often used marijuana to relieve or avoid experiencing marijuana-related withdrawal symptoms. (SCID-IV, question 7)

_____ You were frequently high or recovering from being high when you were supposed to be attending to your obligations at work, school, or home. (SCID-IV, question 8)

_____ You were frequently high or recovering from being high when you were doing something dangerous like driving a car. (SCID-IV, question 9)

_____ You have gotten into trouble with the law because of your marijuana use. (SCID-IV, question 10)

Personal Feedback Report (continued)

_____ You have experienced problems with family members, friends, or people at work because of your marijuana use. (SCID-IV, question 11)

As you reflect on the consequences of smoking marijuana and how they affect your life, what else might you add?

_____

_____

_____

Part III. Your Reasons for Quitting Marijuana

You listed the following personal reasons for quitting marijuana and said that they applied to you moderately, quite a bit, or very much at this time.

_____ To show myself that I can quit if I want to

_____ Because I will like myself better if I quit

_____ Because I won't have to leave social functions or other people's houses to smoke

_____ So I can feel in control of my life

_____ Because my family and friends will stop nagging me if I quit

_____ To get praise from people I'm close to

_____ Because smoking marijuana does not fit in with my self-image

_____ Because smoking marijuana is becoming less socially acceptable

_____ Because someone has told me to quit or else

_____ Because I will receive a special gift if I quit

_____ Because of potential health problems

_____ Because people I am close to will be upset if I don't quit

_____ So that I can get more things done

_____ Because I have noticed that smoking marijuana is hurting my health

_____ Because I want to save the money I spend on marijuana

_____ To prove that I'm not addicted to marijuana

Personal Feedback Report (continued)

_____ Because there is a drug-testing policy at work

_____ Because I know others with health problems caused by smoking marijuana

_____ Because I am concerned that smoking marijuana will shorten my life

_____ Because of legal problems related to marijuana

_____ Because I don't want to be a bad example for children

_____ Because I want to have more energy

_____ So my hair and clothes won't smell like marijuana

_____ So I won't burn holes in clothes or furniture

_____ Because my memory will improve

_____ So that I will be able to think more clearly

You listed these reasons because they have personal significance for you. Do you have any other important reasons for quitting that you would like to add?

_____

_____

_____

_____

Your number of personal reasons for quitting marijuana is ____.

Part IV. Difficult Situations for Maintaining Abstinence

You predicted your most difficult situations for maintaining abstinence from marijuana. These high-risk situations include

_____ Doing monotonous work

_____ Wanting to feel more confident

_____ Vacationing

_____ Seeing someone else smoking marijuana and enjoying it

_____ Feeling depressed or worried

Personal Feedback Report (continued)

_____ Drinking alcohol

_____ Feeling like celebrating good news or an accomplishment

_____ Feeling frustrated

_____ Wanting to feel better about myself

_____ Feeling angry about something or someone

_____ Enjoying a pleasant social situation

_____ Having some time to myself, free of responsibilities

_____ Using other drugs recreationally

_____ Being at a party with people who are smoking marijuana

_____ Feeling embarrassed

_____ Being with a spouse or close friend who is smoking marijuana

_____ Being in an uncomfortable social situation

_____ Being offered marijuana by someone

_____ Being bored, with nothing to do

_____ Feeling stressed out and needing to calm down

As you think about highly tempting situations, are there situations that you'd like to add?

_____

_____

_____

Your responses indicate how confident you are that you could avoid smoking marijuana in these situations and resulted in an SE Score of ____.

This places you in the ____th percentile compared with other adults who have sought counseling to help them stop smoking marijuana.

This means that you are more confident that you could resist the temptation to smoke marijuana than ____ percent of treatment-seeking individuals.

SECTION V.
ENHANCING MOTIVATION: SESSIONS 1 AND 2

This section presents the content of sessions 1 and 2. It also presents information on motivational interviewing and the stages-of-change concept. The counselor uses this concept throughout the remaining sessions to measure the client's readiness for change and to adjust the sessions to accommodate the client's stage. The section provides examples of motivational interviewing strategies, highlighting how to use these techniques in treatment sessions. Finally, it presents sessions 1 and 2; these sessions are based primarily on principles of motivational enhancement and secondarily on cognitive behavioral skills.

After completing the initial assessment session, the counselor introduces the client to more targeted motivational strategies. Session 1 focuses on

- Reviewing the completed *Personal Feedback Report* (PFR)
- Exploring the client's experiences with marijuana
- Eliciting, acknowledging, and reinforcing the client's expressions of motivation to change
- Building the alliance between the client and counselor
- Integrating the client's feedback about marijuana use and associated problems
- Setting goals
- Planning treatment.

The protocol for session 2 guides the counselor in

- Reinforcing successful efforts the client has made at initiating change
- Discussing how and when assistance may be offered by the friend or relative invited to the session by the client
- Refining goals
- Reviewing change strategies
- Assessing the client's social support for initiating changes.

Key Concepts: Motivational Interviewing Skills

Identifying the Individual's Stage of Change

The stages-of-change model (Prochaska and DiClemente 1982) describes a sequence of stages through which individuals progress as they think about and change their behaviors. It gives the counselor insight into the client's thinking so that the counselor can select strategies specific to the client's stage. This model was adapted for the Marijuana Treatment Project and assumes

- Progress in overcoming marijuana dependence (e.g., getting ready for the first day of abstinence, getting through the first 3 months) depends on the client's readiness for change.
- Client readiness may shift and evolve and may be influenced by the therapist.

The model comprises five stages: precontemplation, contemplation, preparation, action, and maintenance (exhibit V-1). Individuals move back and forth between the stages and progress through the stages at different rates. For example, in the assessment session the client may be committed to maintaining abstinence, but in session 2 he or she may be ambivalent. The Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*), as well as the *KAP Keys* (CSAT 2001*c*) and the *Quick Guide* (CSAT 2001*d*) that accompany TIP 35, provides detailed information about this model.

Exhibit V-1. Characteristics of the Stages-of-Change Model

Stages	Characteristics
Precontemplation	• Is not considering change • May be unwilling to change behaviors • Is unaware of adverse consequences from marijuana use, although others may believe problems exist
Contemplation	• Becomes aware that problems exist • Recognizes causes for concern and reasons to change • Typically is ambivalent and continues to use marijuana • May seek information and reevaluate marijuana use behavior • Weighs the pros and cons of making a change • Could remain in this stage for years
Preparation	• Commits to changing • Recognizes that advantages of changing outweigh benefits of not changing • Thinks about capabilities of success (i.e., self-efficacy) • Continues using marijuana but intends to stop or cut back soon • May have attempted to reduce or stop use • Sets goals and may tell others about them
Action	• Chooses and begins to pursue a goal • Modifies habits • Can last months following termination of marijuana use
Maintenance	• Makes efforts to sustain gains achieved during the action phase • Works to prevent recurrence of use • Learns how to detect and guard against risky situations • Requires prolonged behavior change and continued vigilance for 6 months to several years

Using Motivational Interviewing Strategies

Sessions 1 and 2 rely heavily on the motivational interviewing strategies described in Miller and Rollnick (2002). Motivational interviewing is a technique used in motivational enhancement therapy (MET). The counselor assesses the client's motivation by using motivational interviewing strategies, which include asking open-ended questions, listening reflectively, affirming the client, summarizing the client's views of change, eliciting self-motivational statements, recognizing and addressing resistance, recognizing readiness for change, and identifying discrepancies (see CSAT 1999*b*). Once the client's stage is identified, the counselor uses these strategies to support continued progress through the stages.

Close- Vs. Open-Ended Questions

Close-ended questions are an efficient way of obtaining information quickly; however, they allow the client to be passive, answering each question and quietly waiting for the next. The interviewer is in control, and the interviewee responds to each cue. Open-ended questions encourage the client to express himself or herself and to adopt an active role in his or her treatment. Exhibit V-2 presents examples of both types of questions.

Exhibit V-2. Examples of Close- and Open-Ended Questions

Close-Ended Questions	Open-Ended Questions
• How old were you when you first smoked marijuana? • Was it offered to you by a family member? • How old were you when you began using it daily? • Have you ever had a bad experience with marijuana? • When did you first think you had a marijuana problem?	• Tell me about your early experiences with marijuana. • How did your marijuana use change over time? • Please describe some of your recent experiences with marijuana. • What was it that made you think you had a problem with marijuana?

Listening Reflectively

A reflection can take the form of simply repeating the client's words or paraphrasing his or her comments. Sometimes the reflection adds to what the client has said as a way of testing a counselor's hunch. The skilled listener using reflective listening skills can help the client explore his or her thoughts and feelings:

Miguel (M): *I've tried to quit before but have never made it for longer than a month.*

Counselor (C): *Keeping it going has been hard.*

M: *Yeah. I can't help feeling pessimistic about what will happen if I try it again.*

or

M: *My wife is pressuring me to quit. I've got to want to do it for me if this is going to work.*

C: *Pressure from your wife is distracting you from tuning in to your needs about quitting.*

M: *It's almost as if I resist because I want to feel that she doesn't control my life.*

or

M: *My buddies say they'll support me if I decide to quit, but knowing that they're getting high will make me feel left out.*

C: *You'd like to figure out a way to stay connected to these friends and stop smoking.*

M: *I guess I've been thinking that's not possible.*

A double-sided reflection captures two opposing sides to an individual's ambivalence:

Linda (L): *I know I'm getting high too much, but it's summer and I want to have fun before school starts.*

C: *On the one hand, you don't want to miss having fun during the summer, but on the other hand, you're thinking that you use too often.*

Affirmation of the Client

Admitting drug dependence, seeking help by enrolling in a program, summoning the courage to change, and undertaking other aspects of overcoming a dependence are tremendously difficult. The counselor can be supportive by frequently offering genuine compliments and expressions of awareness:

C: *You've been thinking about quitting for a long time, and now you're taking the first steps. I'm guessing you feel good about that.*

C: *Telling your father that you needed counseling for a marijuana problem must have been difficult.*

C: *Deciding to give up the extra income that came from selling pot wasn't a minor decision. It requires a real commitment to leave that behind.*

Summarizing the Client's Views of Change

As the client reveals facets of his or her thinking about change, the counselor can be supportive by summarizing key issues. Hearing the counselor consolidate the client's statements helps the client become aware and ready to resolve his or her mixed motivations:

C: *If I understand you correctly, you're aware of reasons for changing but you're thinking of other reasons not to quit. On the side of quitting are being a good role model for your children and overcoming a tendency to procrastinate. On the side of not quitting are your fears that you'll lose friends and won't make it for long. Have I got it right? What are your thoughts about this?*

Eliciting Self-Motivational Statements

Whereas some clients begin counseling with a strong commitment to stop marijuana use, others have considerable ambivalence that may increase over time. Motivational enhancement sessions help the ambivalent client strengthen his or her determination to quit. It is hoped that these counseling sessions lead the client to recognizing his or her problem *(I guess I really have to face that I'm out of control with marijuana)*, becoming concerned about it *(I'm worried about whether I can overcome this)*, expressing an intention to change *(Now's the time for me to leave this behind)*, and feeling positive about the prospects of succeeding *(I can picture a time when I'll be clean, and—for once in my life—that seems possible)*. The counselor elicits expressions of motivation from the client with open-ended questions:

- **Recognizing the problem**
  - **C:** *How has your marijuana use gotten in the way of things that are important?*
  - **C:** *What convinces you that marijuana has become a problem?*
- **Expressing concern**
  - **C:** *What aspects of your marijuana use have made you, or people close to you, worry?*
  - **C:** *What do you imagine could happen if you continued to smoke marijuana the way you have been doing?*
- **Encouraging intentions to change**
  - **C:** *When you joined our program, you probably had some hope that things would get better. What would improve in your life if your hopes were met?*
  - **C:** *Why should you stop smoking marijuana? Why do you think it's time to change?*
- **Expressing optimism**
  - **C:** *What leads you to think that you could succeed in quitting if you decided to do that?*
  - **C:** *Is there a part of you that feels encouraged about changing?*

With these questions, the counselor helps the client take ownership of the problem and elicit expressions of readiness to change.

Recognizing and Addressing Resistance

A conventional way of interpreting actions of a client who argues with the counselor, frequently interrupts, or denies that a behavior is a problem is that the individual is not motivated to change. An alternative view is that the counselor does not understand the client's thoughts and feelings. When the counselor considers these behaviors a signal that he or she needs to understand the client's experience better, a confrontation between counselor and client is less likely to occur. The counselor shows that he or she is listening and is not being judgmental. The counselor's reflections can prompt the client to explore his or her thoughts and feelings:

M: *I don't understand why you folks want everyone to quit smoking dope. Maybe I'd be better off if I just cut back.*

C: *I hear you saying that it's important to you to change your marijuana use, but you're not sure whether stopping completely is best for you right now. I can see that you're eager to find the best goals.*

In this example, the counselor might have offered a defense of the program's abstinence objectives, listed reasons why the client ought to change, and so forth. Those responses probably would have led the client to become even more resistant. The strategy illustrated above is termed "rolling with resistance," an approach that conveys the counselor's acceptance of the client's point of view and invites the client to be open to a slight variation. In the following examples of this approach, the counselor accepts the client's comments, conveys empathy for the client's feelings, and reframes what has been said:

M: *Most of the people I know get high. Why is everyone on my back?*

C: *It's hard to figure out why you're getting all this pressure. Kind of makes you wonder how you could be the only one who is having problems with pot.*

or

M: *I know I'll have more energy if I quit, but I need it to relax.*

C: *On the one hand, you'd benefit from more energy. On the other hand, you'd need to find other ways to relax.*

or

M: *I can't see living for the rest of my life without getting high.*

C: *Slow down. It's too early to be talking about forever. Let's talk about what you're working on right now.*

or

M: *I think a lot about quitting, but I've never really tried it.*

C: *You've invested a lot of time and energy in this already.*

Recognizing Readiness for Change

Expressions of motivation take a variety of forms. The counselor needs to listen carefully and acknowledge those expressions:

M: *I hate having so many people angry at me. Why don't they get off my back?*

C: *It's important to find a way to stop people from being angry with you.*

or

M: *One thing that I see happening over and over is my promising that I'll limit how often I get high, and then I go right ahead and break every one of these promises.*

C: *You'd really like to stop disappointing yourself.*

or

M: *I've got three beautiful children, and I don't want my pot smoking to interfere with my being a good father.*

C: *An important priority in your life is your role as a father.*

Identifying Discrepancy

Clients who are drug dependent have probably seen their reliance on drugs interfere with important aspects of their lives. The counselor helps the client focus on the costs of continued drug use by pointing them out to the client and seeking the client's perspectives:

C: *I've heard you talk about how important it is that your children grow up in a safe and happy home. That's a goal. But you've also talked about not wanting anyone, including your wife, to dictate what you do, and this is causing tension in your home. Relieving this tension is another goal. I wonder what your thoughts are about these two goals.*

C: *You've told me that when you smoke a joint on your lunch break, you have a hard time concentrating at work for the rest of the day. You've also said that doing your job well is important so that you can get promoted. I'm a little confused.*

The Context for Motivational Interviewing and Skills Training

As the client expresses increasing interest in addressing his or her problems modifying use, the counselor carefully supports these efforts to change without *prescribing* the change. When the client expresses a commitment to change, the counselor asks the client about the steps he or she will take to make the change. The counselor provides a menu of self-change and assisted-change options depending on the client's inclinations and experience in making changes.

It is important for the counselor to show genuine interest in the client's perspectives on and skills for making change. For example, if the client has quit smoking tobacco, lost a lot of weight, or left a destructive relationship, the counselor explores these experiences to reinforce and highlight the client's capacity and desire for self-development. Self-change advice may be in the form of a brief written handout concerning behavioral changes. Sessions 1 and 2 provide several take-home handouts that reinforce motivational advice given by the counselor during the sessions. These handouts are available at the end of this section.

Tips for the Counselor

- Review relevant sections of the manual before each session.
- Develop a natural style of conveying the material; avoid reading text to clients.
- Maintain a motivational style; use open-ended questions and reflections; and avoid a directive, resistance-building style.
- Encourage involvement and participation by the client.
- Attend to shifts in the client's motivation and readiness for change.
- Explain practice exercises carefully; probe for the client's understanding.

Overview of Session 1: Reviewing the PFR

Total Time: 1 hour, 30 minutes

Delivery Method: MET-focused individual therapy

Materials (all forms except the PFR are at the end of this section):

- Two copies of client's completed PFR (form AS8 from the assessment session)
- *Learning New Coping Strategies* (form 1A)
- *A Guide to Quitting Marijuana* (form 1B)
- A blank copy of the *Quit Agreement* (form 1C)

Goals for This Session:

- To present the data gathered during the assessment session concerning marijuana use, its consequences, and the likely benefits and costs of stopping or reducing use
- To facilitate the client's candid reflection on consequences of marijuana use
- To explore the client's attitudes about change, including ambivalent attitudes
- To acknowledge the client's expressions of readiness for change, help set goals, and identify change strategies

Session Outline:

1. Assess the client's readiness to proceed
   - Ask client for his or her feelings and thoughts about the assessment session
   - Ask whether any changes have occurred since the last meeting
   - Reinforce expressions of motivation
2. Review the PFR
   - Age of onset
   - Comparison of use patterns to the national average
   - Problems caused by use
   - Tolerance level
   - Reasons for quitting
   - Risk factors
3. Summarize the PFR review
4. Elicit and reinforce client's readiness to change
5. Assist the client in preparing for change
   - Ask him or her to select a stop date (if the client has not already stopped using)
   - Discuss
     - — Whether the client will stop "cold turkey"
     - — What the client will do with current marijuana supply and paraphernalia
     - — How the client will disclose plans to family and friends

— How the client will address problems in maintaining abstinence

6. Help the client identify specific behavior change strategies
   - Discuss *Learning New Coping Strategies* (form 1A) and *A Guide to Quitting Marijuana* (form 1B)
   - Discuss barriers to quitting and vulnerabilities to slipping
     — Managing general stress (HALT)
     — People, situations, and thoughts that increase vulnerability
     — Significant life changes likely to produce stress
     — Supportive people who will provide help
   - Review previous successful experiences at quitting to identify useful strategies
7. Assign between-session exercises
   - Prepare *Quit Agreement* (form 1C)
   - Review *Learning New Coping Strategies* (form 1A)
   - Review *A Guide to Quitting Marijuana* (form 1B)
8. Ask client to invite a supporter to next session
9. Review and conclude session

Session 1 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor uses MET techniques while reviewing the client's PFR and helping the client prepare for change.

Assess the Client's Readiness To Proceed

The counselor asks the client to express his or her thoughts and any major changes that have occurred since the assessment session. Some possible responses from the client might be

- Abstinence since entering treatment
- A reduction in the client's marijuana use
- Seeking additional treatment or attendance at a mutual-help program
- Conversations about his or her use or about this program with family or friends.

The counselor responds empathically, uses opportunities to support the client's self-efficacy for change, and reinforces expressions of motivation.

Counselor (C): *Thank you for being on time. How are things going?*

Shirley (S): *After answering all those questions about my smoking, I am more aware of it than ever! Nothing has changed yet, but I am thinking about it. My husband has been very supportive.*

C: *And his support means a lot to you.*

S: *You bet! He is someone I can count on.*

C: *That's good to hear. Let's be sure to talk about specific requests you might make of him for support in the future.*

or

C: *You arrived a little late for your appointment. Is this a good time for you, or would a different time work better?*

Doug (D): *No; this is fine. There was a lot of traffic.*

C: *How are things?*

D: *Worse. My wife and my son are on my back; they are treating me as if I'm a leper.*

C: *That sounds like an uncomfortable situation for you.*

D: *Yeah; I feel like everyone is against me.*

C: *How has this affected your smoking?*

D: *At times I find myself smoking just to prove that it's not a problem for me!*

C: *It's more of a problem for them.*

D: *That's right. I don't think either one really understands me.*

C: *You'd like them to understand you; that might remove some reasons for getting high.*

D: *Yeah. At least I wouldn't be trying to get back at them.*

Review the PFR

The PFR review takes approximately 30 minutes. The counselor explains that by reviewing the PFR (form AS8), the client will understand reasons for and against changing and what and when problems might arise.

The counselor leads the client through a systematic review of the PFR, giving the client an opportunity to explore each point. The counselor avoids simply verifying the information obtained during the assessment session. The counselor periodically seeks the client's thoughts and feelings during the review. The counselor listens reflectively to acknowledge expressions of readiness for change. Reviewing the PFR provides an ideal opportunity to use motivational interviewing techniques, for example, expressing empathy, identifying discrepancy, eliciting self-motivational statements, rolling with resistance, and supporting self-efficacy.

The client may respond to elements in the PFR review with arguments about the validity of the items *(I didn't say smoking pot was causing me money problems!)*. In such cases, the counselor maintains a nondefensive tone, acknowledges that the client knows best which areas of his or her life have been affected by marijuana use, and moves on to the next item. The counselor may make changes to the PFR based on the client's feedback during this review.

In keeping with the MET approach, the counselor uses open-ended rather than close-ended questions. For example, *Did you say you used in unsafe situations?* is a close-ended question that invites a mere yes or no answer and possible disagreement with the PFR item. Saying instead *Tell me about using in unsafe situations* invites elaboration and discussion.

The counselor spends more time on the sections that are likely to produce the most constructive discussion. The sections on marijuana problems and reasons for quitting are especially conducive to motivational interviewing. After reviewing the PFR with the client, the counselor asks the client for reactions and responds to them with empathy. Before moving on to the next phase of this session, the counselor ensures that the following PFR items are discussed:

- **Age of onset (part I of the PFR).** The counselor tells the client that substance use disorders tend to be more severe when they begin at an early age. This means that the earlier the age of onset, the greater the risk of developing severe problems if the substance use continues. In the PFR, the age of onset of regular marijuana smoking is the age the client began smoking marijuana three or more times a week.
- **Comparisons of use patterns (part I of the PFR).** When preparing the PFR, the counselor uses tables A and B to compare the client's use with that of others who use marijuana. The percentiles indicate the percentage of people in the comparison group who scored at or below the client's score. These comparisons allow the client to compare his or her use with that of people who experienced significant problems related to marijuana use. The counselor can present the information in the following way:

  C: *You smoked marijuana on 24 of the past 30 days. That puts you in the top 98 percentile relative to all Americans. This means that 98 percent of American adults smoke less often than you do and about 2 percent smoke more often.*

  S: *Wow!*

  C: *That surprises you.*

  S: *It sounds like a lot. I never thought it was that much!*

  C: *What are you thinking, now that you know that?*

  S: *I don't like it. I knew I was getting high a lot, but I always thought that a lot of other people got loaded as much as I did. This isn't good news.*

  C: *You'd like this to be different.*

  S: *Yeah.*

- **Problems caused by marijuana use (part II of the PFR).** The counselor tells the client where he or she falls, relative to others seeking treatment, based on his or her responses to the *Marijuana Problem Scale* (form AS5) and the data in table C. The counselor reviews the criteria listed on the *Structured Clinical Interview for DSM-IV* (SCID-IV) (form AS4) that were coded as 2 or 3. The results provide an overview of the problems and symptoms that the client identified as resulting from his or her marijuana use.
- **Tolerance level (part II of the PFR).** Question 6 of the SCID-IV was used to measure the client's tolerance level. Tolerance is defined as the need for a markedly increased amount of marijuana (at least a 50-percent increase) to achieve the desired effect or a markedly diminished effect with continued use of the same amount of marijuana.
- **Reasons for quitting (part III of the PFR).** To reinforce the client's motivation, the counselor reviews the reasons the client gave on the *Reasons for Quitting Questionnaire* (form AS6) and asks the client whether he or she would like to add other reasons to the list.
- **Risk factors for relapse (part IV of the PFR).** The counselor points out the risky situations the client identified on the *Self-Efficacy Questionnaire* (form AS7) as the client's risk factors

for relapse. The counselor explains that risk factors are warning signs that require the client's attention and indicate a susceptibility to problems associated with marijuana use. A person who uses substances besides marijuana is at risk for additional reasons. Decreased use of one drug may result in increased use of another, a phenomenon called substance substitution. In addition, combining different drugs compounds their effects, sometimes with dangerous results. Tolerance for one substance can increase tolerance for another; people who take multiple substances simultaneously can develop cross-tolerance for several substances and be at risk for injury, arrest, or overdose if severely intoxicated.

Summarize the PFR Review

The counselor summarizes the highlights from the PFR, including reactions and modifications offered by the client during this session:

C: *Let's review and summarize what we've talked about so far. How does that sound to you?*

S: *I'm ready!*

C: *Your PFR shows that your smoking has caused several problems including missing work, difficulty sleeping, and feeling bad about your use. Is there anything else you want to add?*

S: *No; those are the main problems.*

C: *You also mentioned reasons for quitting, including so your husband will quit nagging you, so you won't lose the privilege of teaching, and because you have health concerns.*

S: *Being a good teacher is really important.*

C: *Being a good teacher is important to you, and your smoking gets in the way. You can't properly prepare for class; the kids can find out; you can lose your job.*

S: *It's my biggest reason for wanting to stop.*

C: *When you talk about being a teacher, you get enthusiastic, but when you talk about your smoking, you get discouraged.*

S: *I never noticed that before, but you're right.*

C: *You also stated that high-risk situations for you would include being with others who smoke and seeing them enjoy it. Anything else?*

S: *Not really, but that is a major concern for me as I try to quit. So many people in my life use drugs.*

C: *You've already identified how difficult it may be, but you've also identified some very strong reasons for changing your smoking habits.*

S: *I know it'll be difficult, but I think it's worth it.*

C: *Despite the obstacles, you're ready to take on this challenge.*

S: *I really am.*

Elicit and Reinforce Client's Readiness To Change

When the client expresses motivation to change, the counselor acknowledges these expressions, seeks elaboration, and offers reinforcement:

C: *You said that your smoking has caused problems including feeling that you have lower energy. Could you tell me about that?*

Miguel (M): *I find I mean to do things, but they never get done. It seems that I'm tired all the time. I can't help but think it's related to my smoking.*

C: *Related to your smoking?*

M: *I don't think it affected me when I was young. But now, well, I'm not getting any younger!*

C: *You think smoking is affecting you more as you get older. You feel less productive.*

M: *I think that's related to the lower energy. I don't finish my work at my job, and I'm not as creative. I feel that I'm drowning in backed-up work at home, at my job, everywhere.*

C: *And you think that if you quit smoking, you will increase your productivity.*

M: *Yeah.*

C: *That's important to you. You'd like to regain your creativity and productivity.*

M: *I really would like that.*

Assist Client in Preparing for Change

The counselor assists the client in preparing to stop using marijuana by discussing several key issues. If the client has not stopped already, he or she needs to select a day to stop. The counselor helps the client consider several alternative stop dates.

Topics to consider include what the client will do with his or her marijuana supply and paraphernalia, how the client will disclose the plan to stop to family and friends (both supporters and those who might sabotage the client's efforts), and how the client will address possible problems in maintaining abstinence (e.g., sleep difficulties, boredom, anxiety, restlessness) in the first week.

Help Client Identify Specific Behavior Change Strategies

The counselor discusses specific coping strategies to handle vulnerabilities to slipping. The counselor gives the client *Learning New Coping Strategies* (form 1A) and *A Guide to Quitting Marijuana* (form 1B). If time permits, the counselor reviews these forms with the client, highlighting sections that seem particularly relevant to the client. The counselor explains that many concepts touched on in the forms are discussed in detail in later sessions and the client should bring the forms to the next session (session 2).

Because managing one's stress level is important, particularly in the early weeks and months of treatment, the counselor advises the client about HALT:

- Don't let yourself become too **H**ungry.
- Don't let yourself become too **A**ngry.
- Don't let yourself become too **L**onely.
- Don't let yourself become too **T**ired.

The counselor asks the client to think about people, situations (e.g., certain times of day, days of the week, places, moods), and thoughts that can increase vulnerability to slipping. Some of these

were mentioned on the *Self-Efficacy Questionnaire* (form AS7). For example, a client may describe plans to spend time with a smoking buddy. A client may face significant life changes (e.g., job or relationship changes, illness in the family or of a close friend) likely to produce stress that could place the client at risk for slipping. The counselor and client identify and discuss coping strategies for each situation.

The counselor helps the client identify people from whom he or she can seek and get support. The counselor encourages the client to consider several options rather than only one or two and to think creatively. With the counselor, the client can practice making requests and can benefit from the counselor's modeling and feedback. Practicing interactions during treatment sessions can lessen the anxiety the client may have about asserting himself or herself with friends and family:

M: *I'll be going away for a few days, and I have concerns that no one will be watching me.*

C: *What concerns do you have?*

M: *I'll be at a meeting with several people who smoke. For years we've gone out and partied after the meetings. I don't know what I'll do.*

C: *You just identified a high-risk situation.*

M: *Yeah. What should I tell them? I thought about saying I had a cold, but that's lying.*

C: *You would prefer to tell them the truth. What are your concerns about that?*

M: *I guess I'm afraid they would think I'm judging them. I really like these people.*

C: *That is a difficult situation for you. Maybe if you and I rehearsed a couple of different ways to tell them, it would make it easier for you. Would you be willing to try that?*

M: *Sure, what should we do?*

C: *Why don't I play the role of one of your colleagues on this trip, and you try different ways you might handle it. Ready?*

Assign Between-Session Exercises

The counselor gives the client the *Quit Agreement* (form 1C) and asks the client to bring the completed form to the next session. The counselor explains that the agreement summarizes

1. The client's date for quitting marijuana use
2. The client's reasons for seeking to change
3. Strategies that the client will use.

The counselor also asks the client to review *Learning New Coping Strategies* (form 1A) and *A Guide to Quitting Marijuana* (form 1B) several times before the next session.

Ask Client To Invite a Supporter to Next Session

People who are trying to overcome an addiction can benefit greatly from the support of a close relative or friend. The counselor asks the client to invite someone to attend the next session and to think carefully about the pros and cons of particular people to invite. For example, a friend who is dependent on another drug or alcohol is not a good prospect. Factors to consider include

closeness to the client, emotional characteristics of the relationship, emotional availability of the supporter regarding the client's desire to quit marijuana use, substance use by the supporter, and accessibility during times of stress. The ideal person would be someone who is a good listener, cares about the client, and is interested in providing support. This person will be asked to sign the *Supporter Agreement* at session 2.

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, troubleshoots any difficulties, and reminds the client to review the handouts over the next week.

Overview of Session 2: Change Plan, Treatment Plan, and Supporter Involvement

Total Time: 1 hour

Delivery Method: MET-focused individual therapy with case conference elements

Materials (all forms except the PFR are at the end of this section):

- Copy of client's PFR (form AS8)
- *Learning New Coping Strategies* (form 1A)
- Blank copy of the *Quit Agreement* (form 1C)
- *Supporter Strategies* (form 2A)
- Two blank copies of *Supporter Agreement* (form 2B)

Goals for This Session:

- To specify how a supporter can help the client achieve and maintain change
- To help the client develop a change plan with coping strategies for high-risk situations

Session Outline:

1. Assess client's progress and readiness to proceed
   - Ask client how he or she feels about continuing therapy
   - Address client comments and questions about session 1 handouts
   - Review the client's *Quit Agreement*
2. Welcome supporter
   - Stress importance of supporter's participation
   - Provide basic information about intervention
   - Answer questions
3. Examine client's recent experiences
   - Did client make an effort to stop? Cut down?
   - Did he or she experience any high-risk or tempting situations?
   - Did the client use any strategies from *Learning New Coping Strategies?*
   - Were the strategies successful?
4. Examine client's experience with supportive and nonsupportive relationships
5. Discuss ambivalence
6. Establish a change plan
   - Suggest interim goals if client is not ready for abstinence
   - Encourage client to set general and specific goals
7. Involve supporter and review *Supporter Strategies* and *Supporter Agreement*
   - Elicit supporter's concerns and hopes for the client
   - Give supporter *Supporter Strategies* (form 2A)

- Complete *Supporter Agreement* (form 2B)
- Review *Supporter Agreement*
- Help client and supporter decide which items they can agree to
- Review *Supporter Agreement* with client, even if no supporter attends, and role play asking for support

8. Assign between-session exercises
9. Review and conclude session

Session 2 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor helps the client develop a change plan and obtain support from an important person in the client's life.

Assess Client's Progress and Readiness To Proceed

The counselor asks the client how he or she feels about the two previous counseling sessions and responds empathically to his or her concerns. The counselor addresses any client comments or questions that have arisen since the previous session about the PFR (form AS8), *Learning New Coping Strategies* (form 1A), or the *Quit Agreement* (form 1C). The counselor reviews the *Quit Agreement* with the client and discusses adjustments (e.g., Is the client setting unrealistically high standards that may set him or her up for failure? Has the client identified salient reasons for wanting to make changes in marijuana use?). The counselor photocopies the agreement to maintain a record of client goals.

Welcome Supporter

If the client has brought a supporter, the counselor welcomes him or her and thanks the individual for his or her willingness to participate. The counselor provides general information about the intervention and asks whether the supporter has questions.

In the course of the session, the counselor

- Provides the supporter with information and answers his or her questions about the treatment
- Fosters motivation by encouraging the supporter and client to discuss the effect of the client's marijuana use on their relationship
- Formulates a change plan
- Identifies how the supporter can help the client with treatment goals and abstinence.

The counselor emphasizes the importance of the supporter's participation and indicates that in a few minutes the counselor will want to hear more from the supporter but that first the counselor will talk with the client about what has been happening recently:

Counselor (C): *I want to thank you both for coming today. Shirley has told me how much help you've been to her. We'll meet for about an hour today to discuss your role as a supporter for Shirley. Does either of you have any questions?*

Husband (H): *I want you to know how proud of her I am; I'm willing to do whatever I can to help her out.*

C: *That's very encouraging to hear. Before we begin, I'd like to take a few minutes to ask Shirley how things have been going since we last met.*

Examine Client's Recent Experiences

The counselor asks the client to describe his or her recent experiences with marijuana:

- Did the client stop use since the previous session?
- Did the client make an effort to stop?
- Was the client confronted with any high-risk or tempting situations?
- What strategies did the client use? Did the client try any of the strategies in *Learning New Coping Strategies* (form 1A)? Were they successful?
- Were there any instances when the client effectively handled a "hot" situation (i.e., very high risk)?

The counselor acknowledges client efficacy and reinforces the strategies that the client found useful. The client's report on the week's events provides the counselor with an opportunity to use motivational interviewing techniques. As the client talks, the counselor's objective is to elicit information and to use that information to provide reflections, express empathy, identify discrepancies, elicit self-motivational statements, and roll with resistance:

Shirley (S): *Well, I've almost completely stopped smoking since our last session.*

C: *You seem very pleased with yourself! How did you do that?*

S: *Right after the last session I kept thinking about how pot has kept me from doing the things I want to do. I really want to be a teacher, and I realized that as long as I kept smoking, I would always feel bad. So I went home and smoked one last time, then flushed the remainder of my stash down the toilet! During the last week I've wanted to get high several times, but I didn't.*

C: *What did you do when you felt like smoking?*

S: *Well, I talked to my husband. I read about that in the handout you gave me last week.*

Examine Client's Experience With Supportive and Nonsupportive Relationships

The counselor helps the client reevaluate relationships that have enhanced or impeded change:

C: *Talking to someone else helped.*

S: *Yes, it did. And I kept cards and notes from my students in my purse and would take them out and look at them. Boy, I love those kids!*

C: *Your love for the children you teach and your husband's support are powerful tools!*

S: *You bet!*

or

Doug (D): *My wife chose not to come today. She says this is my problem, and I need to solve it or find a new wife. After all these years of me smoking around her, now she wants immediate change and doesn't want to help me!*

C: *As you work on making changes, you may not have the support you would like. How are things different since we met last?*

D: *I've tried to cut down to a couple of days a week, but it's harder than I thought.*

C: *When you were successful, what did you do differently?*

D: *I didn't take pot to work 2 days last week, so I couldn't smoke. It wasn't that bad. If I didn't have it in my car, I didn't leave work on an "errand" to smoke.*

C: *You found that you could make changes if you didn't have marijuana in easy reach, and it may have been easier than you thought it might be. Did other things help?*

Discuss Ambivalence

The client may be reluctant to disclose ambivalence for fear of disapproval. However, strong ambivalence may be manifested in nonverbal behavior and possibly in an impaired therapeutic alliance (e.g., missed sessions, reluctance to establish treatment goals). The counselor needs to be vigilant about maintaining the client's level of motivation for change and engagement in treatment.

Establish a Change Plan

The counselor helps the client establish a long-term plan for behavior change, focusing particularly on the next 12 months. The counselor summarizes indications of motivation that the client has made. If the client has given no indications of a desire to change, he or she may not be ready to commit to change, and the counselor points this out.

The counselor explains that articulating goals increases the likelihood that the counseling will be meaningful and useful. For clients whose goal is immediate and permanent abstinence, articulating goals is straightforward. However, many clients are not at this stage of change early in treatment. If clients say they are not ready to give up marijuana, the counselor suggests setting other interim goals such as learning more about the skills that will help them quit or reduce marijuana use in the future. Goals may be general, such as quitting marijuana use within the next 2 weeks or reducing marijuana use to no more than four joints per week. Other goals may be more specific. For example, the client may set goals of figuring out how to stay away from substance use opportunities, identifying ways to get past cravings, learning new social skills, and participating in activities that are incompatible with marijuana use. Although the program's goal is to help clients achieve abstinence, the counselor needs to meet the clients where they are to avoid alienating them and to keep the door open for improvement and possible future abstinence.

Involve Supporter and Review Supporter Strategies *and* Supporter Agreement

If a supporter is attending this session, the counselor shifts the focus of the session to the relationship between the client and supporter. The counselor asks the supporter why he or she

wants to participate, eliciting the supporter's concerns and hopes for the client. The counselor gives the supporter *Supporter Strategies* (form 2A) and reviews its contents.

The counselor introduces the *Supporter Agreement* (form 2B), and the client and supporter read the list to determine which items they will agree to:

C: *We have a list of ideas and strategies that have been helpful for some people. Let's see whether any of these could work for you two.* [To husband] *As we begin to look at ways that you and your wife can work together on this change, what concerns do you have?*

H: *Shirley has a habit of getting excited about something and then giving up when things get tough. I want to help, but I'm not going to nag her. This is something she's going to do, not me. I'll help, but I won't push her.*

C: *You recognize that Shirley needs to make her own decisions, and you don't want to be a policeman, is that right?*

H: *Pretty much, but I don't want to give you the idea that I won't support her.*

C: *It sounds as if you have some ideas of what you would be willing to do. I've given the two of you a* Supporter Agreement. *We've listed some ways that Shirley might reach her goals. As we look at these together, I'd like you to identify some things you might be willing to do. How does that sound?*

Even if the client has not brought a supporter to the session, the counselor reviews the *Supporter Agreement*. The client may choose to identify a supporter later. The counselor and client can role play ways of asking for support.

Assign Between-Session Exercises

The counselor asks the client to continue reviewing the forms handed out at this session and last week's session.

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor should also discuss with the client the likely scenarios for future treatment sessions. For example:

C: *When we meet next time, we're going to shift gears somewhat. I'm going to talk with you about other areas of your life besides your marijuana use—areas in which you may be experiencing difficulty. These problems may be directly related to your marijuana use, but not necessarily. We're going to work on these other areas of life because doing so may help you be successful in your goal to stop using marijuana.*

Forms for Sessions 1 and 2

During the enhancing motivation sessions, the counselor and client review or complete five forms. These forms are provided on the remaining pages of this section.

Learning New Coping Strategies

Some Alternatives to Marijuana Use

You can do many things to stop using marijuana. Some may work better than others. Some help you resist the urge to smoke or avoid tempting situations or satisfy your needs in more constructive ways than smoking marijuana. Expect to try several and add any that may be helpful. Think about what worked when you gave up marijuana before or when you made other changes in your life.

Be kind to yourself as you begin this change process—you're doing something to take care of yourself, and you deserve all the comfort and self-acceptance you can get! Remind yourself that learning and changing inevitably mean giving up old ways and that, in time, you will feel more comfortable. Remember the changes your body and mind went through when you learned to drive, got to know a new person, started a new job, or learned a new skill. Chances are you felt awkward, uncomfortable, silly, dumb, scared, frustrated, impatient, or anxious, in addition to hopeful, excited, and challenged. What helped you then? How long did it take you to feel relaxed? Did you learn all at once, or were improvement and progress gradual?

Actions

Avoid or escape from situations that make you want to smoke marijuana. Sometimes this is the easiest and most effective way to resist temptation, especially at the beginning.

Delay decisions to give in to temptation; for example, you could wait 15 minutes. Take several deep breaths. Focus on the fresh air entering your lungs, cleansing and nourishing your body. Let out tension with each exhalation.

Change your physical position. Stand up and stretch, walk around the room, or step outside.

Carry things to put in your mouth: toothpicks, gum, mints, plastic straws, low-calorie snacks.

Carry objects to fiddle with: a rubber ball to squeeze, a small puzzle, a pebble, worry beads.

Have a distracting activity available: a crossword puzzle, magazine, book, a postcard to write.

Thoughts

Self-talk. Give yourself a pep talk; remind yourself of your reasons for quitting; remind yourself of the consequences of using marijuana; challenge any wavering in your commitment to quit.

Imagery and visualization. Visualize yourself as a nonsmoker, happy, healthy, and in control; imagine your lungs getting pink and healthy; or focus on negative imagery and imagine yourself with cancer, emphysema, unable to breathe, needing constant care. Visualize yourself in a jail made of marijuana cigarettes symbolizing the way marijuana controls your life.

Thought-stopping. Tell yourself loudly to STOP; get up and do something else.

Learning New Coping Strategies (continued)

Distraction. Focus on something different: the task at hand, a daydream, a fantasy, counting backwards from 150 by 3s.

Lifestyle

Exercise or take a brisk daily walk. Get your body used to moving; use stairs instead of elevators; park farther away from your destination; walk instead of drive.

Practice relaxation or meditation techniques regularly.

Take up a hobby or pick up an old hobby you used to enjoy.

Drink less coffee; switch to decaf; drink herbal teas.

Engage in an enjoyable activity that is not work related several times a week.

Change routines associated with smoking marijuana, at least temporarily; for example, don't turn on the TV when you get home from work; don't spend time with friends who smoke.

Social Interactions and Environment

Remove smoking paraphernalia (pipes, papers, bongs, ashtrays, matches, lighters, marijuana) from your home and car.

Go to places where it's difficult to get high, such as a library, theater, swimming pool, sauna, steam bath, restaurant, and public gatherings (not rock concerts).

Spend time with friends who don't smoke. Enlist support from family and friends. Announce that you've quit; ask people not to offer you pot, to praise you for stopping, to provide emotional support, and not to smoke around you.

Learn to be appropriately assertive; learn to handle frustration or anger directly instead of by smoking.

Specific Suggestions for Some Common High-Risk Situations

Below are several high-risk situations that people who use marijuana confront, along with suggestions for coping without smoking.

Tension Relief and Negative Emotions (e.g., depression, anxiety, nervousness, irritability)

Develop relaxation techniques, exercise, write down your feelings or talk to a friend or counselor, do something enjoyable that requires little effort, figure out what you're feeling and whether you can do anything about it.

Learning New Coping Strategies (continued)

Anger, Frustration, and Interpersonal Conflict

Try to handle the situation directly rather than hide your feelings; if appropriate, be assertive; get some release by squeezing a rubber ball, pounding a pillow, or doing some physical activity; write down your feelings or tell them to someone; take deep breaths.

Fatigue and Low Energy

Do muscle relaxations; take a brisk walk; do something enjoyable; eat properly and get enough sleep.

Insomnia

Don't fight being unable to sleep. Get up and do something constructive or relaxing. Read a book, watch TV, or do muscle relaxations until you feel sleepy. Remember that no one dies from losing a night's sleep.

Timeout

Read, do a crossword puzzle, prepare a healthy snack, take up a hobby, knit or do other needlework (things you can carry with you for easy access).

Self-Image

Try a new image: get a new haircut or buy new clothes.

Social Pressure

Be aware when others are smoking. Remember your commitment not to smoke marijuana. Be assertive and request that people not offer you pot. If appropriate, ask that they not smoke around you for a while. If necessary, be prepared to leave the situation, especially when you've recently quit.

Situations Involving Alcohol

After you've quit marijuana, you may continue to associate drinking with smoking pot. Alcohol can make you less vigilant about resisting marijuana. It tends to make people less concerned about long-term consequences. You might consider not drinking or cutting down during the first few weeks after quitting. If you don't want to do this, be especially careful when you drink.

Cravings and Urges

The only way to interrupt cravings is to break the chain of responding to them. That is, don't give in. Eventually they will decrease. Do something to distract yourself; use the techniques listed under Thoughts; breathe deeply; call a friend; go for a walk; move around; time the urge, and you'll find that it will disappear like a wave breaking.

A Guide to Quitting Marijuana[1]

About Marijuana and How It Affects the Body

Cannabis is the general name given to a variety of preparations derived from the plant *Cannabis sativa*. The main psychoactive ingredient in cannabis is delta-9-tetrahydrocannabinol or THC. Some 400 other chemicals also are in the cannabis plant.

When a person smokes marijuana, THC enters the bloodstream through the walls of the lungs and is taken to the brain. THC is stored in fatty tissues and can be detected in urine for days, weeks, or sometimes months. The effects of marijuana depend on the person, the environment, the potency of the drug, and how long the person has been using the drug. It is possible to become addicted to marijuana and feel dependent on it to get through the day. Each year thousands of people seek help to stop using marijuana.

Why Do You Smoke Marijuana?

You may have many reasons for smoking marijuana: to relax, to help you sleep, to calm down. However, meditation or exercise often can accomplish these same results. You may smoke to improve social interactions, but many find that after years of smoking, relationships and social life in general have deteriorated. Or you may smoke to avoid life's problems. However, the problems don't go away by themselves.

Below, identify your specific reasons for smoking.

Why I Use Marijuana

1. _____

2. _____

3. _____

Why Do You Want To Give Up Marijuana?

Researchers, health professionals, and people who smoke marijuana have identified health, social, legal, and financial reasons to quit.

Health Risks

- Respiratory diseases such as chronic bronchitis.
- Changes to cells in the body that may signal the development of cancer. Marijuana smoke contains substantially higher levels of cancer-causing chemicals than does tobacco smoke.

[1]Adapted from Grenyer et al. 1995.

A Guide to Quitting Marijuana (continued)

- Problems with attention, concentration, and memory that get worse with continued use of marijuana and only partially improve after quitting.
- An increased risk of developing cancers in the mouth, throat, and lungs.
- An increased risk of birth defects or leukemia in children exposed to marijuana during pregnancy. Using marijuana also may disrupt sperm production and ovulation.
- Poor educational achievement and difficulties in learning.
- An increase in symptoms for people who suffer from heart disease, asthma, bronchitis, emphysema, or schizophrenia.

Identify the health risks that concern you the most.

Health Fears

1. _____

2. _____

3. _____

Social Reasons for Quitting

Some people give up marijuana because they are tired of their lifestyle and feel they are stagnating. Are you

- Worried that your social life is restricted to people who smoke dope?
- Feeling low and avoiding people?
- Worried that some relationships are not going well?
- Arguing with your partner?
- Aware of your partner's concerns about your smoking?
- Worried about smoking around children?

Many people use marijuana to avoid problems. Often their problems just continue to get worse. Your decision to quit might make some problems seem worse in the short term, but you will feel much better in the long run. You will be able to handle problems better, and the problems caused by your smoking will diminish. Remember: No pain, no gain.

A Guide to Quitting Marijuana (continued)

Financial Costs

Are you concerned about the amount of money you spend on marijuana? In the blanks below, fill in how much you spend on marijuana, and calculate what getting stoned costs you per year.

$_____ per week x 52	or	$_____ per month x 12
TOTAL COST PER YEAR $_____		

You might want to include the costs of tobacco, papers, bongs, and munchies as well as days off work. It all adds up.

Other Reasons for Quitting

What about other hassles? Do you

- Feel addicted to marijuana or unable to control your marijuana use?
- Feel anxious and paranoid?
- Feel as if your thoughts are racing except when you're stoned?
- Have trouble sleeping?
- Feel you are not doing your job properly?
- Drive when stoned?
- Waste time trying to get marijuana?
- Risk getting arrested for growing your own marijuana?
- Worry about getting arrested for possession?
- Have arrests, fines, court hearings, a criminal record, or other legal issues to address?
- Fear going to jail?

How Do You Give Up Marijuana?

If you are serious about quitting, the best way is to stop "cold turkey." You might be surprised that it's easier than you think. Soon after quitting, you'll find that your thinking becomes clearer.

To quit using marijuana, you have to confront your desire to get stoned. You will be going into battle against a part of yourself that you no longer wish to exist. Giving up marijuana, especially if you've been using for some time, is a bit like losing an old friend. Quitting may feel like a funeral, but it is also the beginning of a new life.

Think of quitting as a positive step. You must be well prepared and have a plan worked out in advance. If you follow the suggestions in this guide, you will find it easier to achieve your goal. If you are serious about stopping, it is time to decide when you are going to quit. Review the *Quit Agreement* (form 1C).

A Guide to Quitting Marijuana (continued)

The Decision

Designate a day as Quit Day. Remember that the decision is yours, and the commitment you make to quit marijuana use is with yourself. Sign and date a contract with yourself now. You might want to consider making other changes at this time, such as quitting cigarettes as well.

Quit Strategies

The following strategies may prove useful in quitting:

- Set a date, and stick to it.
- Replace marijuana use with new activities and interests.
- Avoid situations where you used to get stoned.
- Ask a friend for support. You do not have to go it alone.
- Say to others, "I don't get stoned anymore."

Identify several strategies that will help you quit, and write them down.

Three Things I Can Do To Give Up Marijuana

1. _____

2. _____

3. _____

Changing Old Habits

When you used marijuana, you established a link between the situation in which you used and getting stoned. Certain situations, people, and places that you subconsciously associated with smoking may trigger a desire to use. Below list the places where you usually used, other persons present, and your mood just before using. A final item to include is a substitute for the situation.

Where	With Whom	Mood	Substitute
Living room	Alone	Down	Go for a walk

A Guide to Quitting Marijuana (continued)

Check Your Feelings

When you give up using, and for a week or more after, you may feel out of sorts. Several "withdrawal symptoms" are caused by stopping use of marijuana. You might experience

- Anxiety
- Irritability
- Sweating
- Sleep disturbances
- Moodiness
- Tremors
- Nausea.

These experiences are normal. Your body is flushing out the toxins from the marijuana. Take it easy; stay with your determination to quit. These feelings and problems will go away soon.

How Do You Stay Off?

When you have taken the initial steps to quit, you will experience times when you want to break your contract. Resuming old habits is one reason people fail. Alter your lifestyle to accommodate the new you without marijuana. Reread and use the strategies listed on *Learning New Coping Strategies* (form 1A). Write those that will be most helpful in the spaces below.

Strategies I Can Use To Stay Off Marijuana

1. _____

2. _____

3. _____

Lapses

Sometimes you will be unable to fight the urge to use. If you slip, try not to think of it as a failure. Think of it as a lapse in concentration, and renew your commitment to quit. Remind yourself that you are capable of not smoking.

Reward Yourself

Now that you have given up marijuana, reward yourself in new ways. Give yourself a gift at the end of each week that you fulfill your contract. Try to match the cost of the gift with the average weekly cost of getting stoned. You may like to keep a record of this.

A Guide to Quitting Marijuana (continued)

Week	Gift	Cost
Week	Movie and dinner for two	$80

Quit Agreement

I, _____, am quitting marijuana because (fill in reasons for quitting)

_____

_____

_____

_____

_____

_____

_____

As of _____, I intend to stop smoking marijuana and to refrain from use in the future by (fill in strategies to be used)

_____

_____

_____

_____

_____

_____

_____

Signatures: _____ _____

Supporter **Participant**

Supporter Strategies[2]

Maintaining Motivation

Help your partner or friend maintain motivation by keeping it from lagging in the first place. Don't wait for a problem to arise. *Let him or her know how impressed you are with his or her success in quitting marijuana*. Tell him or her that you know the change requires much effort and that you can see the benefits of the change. Don't assume the journey away from marijuana is over when he or she has been abstinent for 2 or 3 months.

If you see signs of motivation dwindling, such as your partner's or friend's starting to talk about using marijuana or wanting to visit friends who still use, ask him or her how he or she is feeling about marijuana use. Don't assume that his or her motivation is decreasing until you've talked about it. Bring up the topic in a noncritical way; perhaps start with a compliment about his or her success. Then ask about his or her motivation for staying away from marijuana.

If you see that motivation is on the wane, offer to help get it back. Review the list of reasons for quitting or the *Quit Agreement* together. Ask whether he or she is feeling deprived and needs some help finding fun things to do.

Don't be critical. Motivation is difficult to maintain. Your partner or friend needs support and encouragement to increase motivation. Criticizing his or her lack of willpower or threatening with ultimatums can provoke a negative mood and lower self-esteem.

Lifestyle Changes

Help your partner or friend make the lifestyle changes that will keep him or her from needing pot. Talk about your observations of his or her lifestyle. Can stress be reduced? What activities can he or she do at those times of the day when he or she might be tempted to use? Can you do any of them together, such as an exercise program? It reduces stress, clears out the lungs, and can be rewarding in many ways.

Having a positive, supportive conversation regularly is important. Lifestyles need to be watched so that people don't slip into old ruts. Talking about the upcoming week and discussing how to build some fun time into it can become a weekly activity.

High-Risk Situations

Help your partner or friend plan for and cope with high-risk situations regularly at least during the first year. After a while, coping with the old week-to-week situations that promote use will become automatic. However, you still need to be on guard for those unexpected or unusual situations for which a coping strategy hasn't been planned or practiced. Examples might include an upcoming vacation, a visit with old friends, unemployment, or an argument with someone. *If you see something coming up that's likely to pose a risk for marijuana use, alert your partner or friend.* Then help plan for coping with the situation if it should occur.

[2]Source: Stephens et al. 2000.

Supporter Strategies (continued)

If an event occurs without a chance to plan for it, you can go straight to a coping mode, distract your partner or friend or offer support depending on the situation. You don't have to point out that you're doing it to prevent a return to pot smoking unless you think that would be helpful.

Coping With a Slip

Chances are a slip will happen. A slip is marijuana use that occurs after a period of abstinence. A slip doesn't mean a person will return to regular marijuana use. That would be a relapse. Slips occur when motivation is lagging or when a high-risk situation occurs unexpectedly. Slips do not mean that all the success and progress to date have been lost. How your partner or friend responds to a slip can mean the difference between returning to abstinence or going into a relapse. Here are some things to do if a slip occurs:

- **Ask your partner or friend how the slip came about.** Did he or she see it coming or was it a sudden urge related to a situation? What was the situation? How was your friend feeling before smoking? Was he or she feeling down or angry or bored or wanting to celebrate?
- **Ask about any attempts at avoiding the situation or coping strategies used in the situation.** If he or she anticipated the situation and made little effort to avoid or cope with it, a motivation problem probably exists. Refer to the ideas in the section above on maintaining motivation.
- **Ask whether any clues could have warned of a difficult situation.** If the urge to use came up suddenly or the coping strategies used simply weren't effective, help your friend learn from this slip to prevent more slips in the future. Help him or her find new coping strategies to use in the future. Suggest other ways of coping.
- **Help your partner or friend regain motivation and learn from what happened.** Come from a position of support and encouragement. If your friend says things like, "I guess I just can't quit" or "Smoking pot's not really that bad," then challenge these statements. You know neither is true.

Your goal is to get your partner or friend back on track, not to punish him or her for slipping. Attack the rationalization *(I'm only going to smoke this one time)* not the person. Say that those statements are rationalizations, they're a symptom of losing motivation, and it's time to focus on getting motivation back. Don't put the person down, criticize his or her willpower, or say the situation is hopeless. Making the person feel bad is likely to promote a return to marijuana use. When you show the person how his or her actions are a sign of losing motivation and show how to get that motivation back, you can help a slip stay merely a slip.

Feeling Appreciated

Does your partner or friend appreciate your efforts? Do you feel that you're working harder at this than he or she is? If so, it's time to talk to him or her about it. You won't be any help if you are feeling burned out and unrewarded.

Let your partner or friend know how you feel without accusing him or her of neglecting you. Point out that this would be a good time to renegotiate the *Supporter Agreement.* Start your conversation with the words "I feel," not "You haven't." Make sure you ask for what you want—a little acknowledgment, a relaxing or fun evening, a chance to talk, or whatever you feel is a reward for your efforts.

Supporter Agreement[3]

In this document, _____ will be referred to as the Supporter and _____ will be referred to as the Participant. To maintain _____'s success in quitting marijuana, we agree to the following arrangements.

Types of Support. ***Supporter and Participant initial all conditions that apply to the agreement.***

Initials

___ ___ Supporter will let Participant know how pleased he or she is with the Participant's success at not using marijuana.

___ ___ Supporter will ask Participant about his or her motivation for remaining abstinent from marijuana if Supporter notices that motivation may be decreasing.

___ ___ Participant will let Supporter know that he or she appreciates the support received.

___ ___ Supporter will remind Participant of his or her reasons for quitting marijuana and of the consequences that marijuana caused, if motivation seems to lag.

___ ___ Participant will review the *Reasons for Quitting Questionnaire* or the *Quit Agreement* with the Supporter if they agree that motivation needs a boost.

___ ___ Supporter will discuss and participate with Participant in lifestyle changes that will reduce the need for marijuana.

___ ___ Supporter will ask Participant about upcoming high-risk situations that Supporter anticipates but is not sure whether the Participant anticipates. In addition, Supporter will help Participant plan to cope with high-risk situations.

___ ___ Supporter will help Participant cope with a marijuana use slip and return to abstinence by asking about Participant's motivation and the circumstances of the slip.

___ ___ Supporter will help restore motivation and develop a coping plan for future situations that led to the slip.

___ ___ Participant will negotiate rewards for Supporter's continued support and involvement.

___ ___ Supporter will avoid being critical of Participant in communicating concerns about motivation, high-risk situations, and slips. Supporter will focus on questioning Participant's motives and coping plans and on challenging rationalizations for using.

___ ___ Participant will listen to what Supporter has to say about observations of lagging motivation, upcoming high-risk situations, or rationalizations for using marijuana.

___ ___ Supporter may express disappointment if Participant fails to accept Supporter's input.

___ ___ Participant will suggest another time (within 24 hours) to discuss Supporter's observations or concerns if Participant's current mood or situation does not allow him or her to be open to Supporter's comments at the moment.

[3]Source: Stephens et al. 2000.

Supporter Agreement (continued)

Specific Conditions or Support Agreements. ***List additional conditions.***

___ ___ _____

_____

_____

_____

_____

___ ___ _____

_____

_____

_____

_____

___ ___ _____

_____

_____

_____

_____

Signatures: _____ _____

Supporter **Participant**

SECTION VI.
CHANGING MARIJUANA USE THROUGH SKILL BUILDING: SESSIONS 3 THROUGH 9

In sessions 3 through 9, the counselor builds on the client's motivation by encouraging the use of specific strategies and skills for accomplishing treatment goals. The counselor offers tools to enhance the client's motivation to change. This approach is based on cognitive behavioral therapy (CBT) models for substance abuse treatment, with an emphasis on relapse prevention. The Center for Substance Abuse Treatment's (CSAT's) Treatment Improvement Protocol (TIP) 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*), as well as the *KAP Keys* (CSAT 2001*a*) and the *Quick Guide* (CSAT 2001*b*) that accompany TIP 34, provides background material on this approach. The CBT sessions follow the approach of Monti and colleagues (1989).

Why Focus on Skills?

Motivation Leads to Skills Development

Once the individual commits to changing his or her behavior, Brief Marijuana Dependence Counseling (BMDC) focuses on building and strengthening skills for becoming and remaining abstinent. The client's motivation and commitment may vary during treatment, but the motivational enhancement therapy (MET) strategies remain integral to treatment.

The counselor begins by reexploring the client's commitment to abstinence and using MET strategies (e.g., rolling with resistance, identifying discrepancies) when the client's motivation wavers. In these sessions, the counselor and client work on developing specific skills (e.g., refusing offers, coping with cravings). This approach is usually slower and somewhat less structured than other CBT approaches, but many individuals who are marijuana dependent find this helpful.

Focusing on the Skills Taught

After completing the engagement, rapport-building, and goal-setting tasks during the early sessions, the client prepares to learn new skills, begins to eliminate problems associated with marijuana use, and addresses other life concerns. During this phase, the counselor coaches the client to develop supportive social connections and establish links with resources to address family, mental, and employment problems. The counselor adjusts the focus, the content of skill topics, and the general approach to meet the client's needs and provides structure and guidance. These sessions typically have a more didactic tone than the earlier sections, which are strictly MET. However, these sessions should *not* be delivered as lectures; the counselor maintains a balance between guiding and teaching, on the one hand, and the client-centered focus of the treatment, on the other.

What Is Cognitive Behavioral Counseling?

A CBT social learning model focuses on teaching interpersonal and self-management skills (CSAT 1999*a*). CBT is a skill-building rather than a deficit-oriented approach. Marijuana dependence is considered a learned behavior that developed in response to external (e.g., environmental, relational) and internal (e.g., feelings, thoughts) conditions. A CBT perspective suggests that the addictive behavior has become a favored strategy because of its repeated associations with predictable outcomes. For example, someone uses marijuana when he or she is sad, angry, lonely, or upset; he or she feels less bad when smoking and associates marijuana use with feeling better (at least in the short term). Over time, marijuana may be selected more often as a strategy to escape negative feelings or thoughts.

CBT views compulsive or addictive behaviors and certain negative moods as learned and not the result of a character defect. Because these behaviors are learned, they can be unlearned. The unlearning occurs through learning new skills and enhancing the client's capabilities.

The client develops skills to identify and cope with high-risk internal states and external situations that increase the likelihood of a slip. The counselor assigns the client homework to practice using the new skills. The client's participation and the counselor's positive feedback enhance client confidence in managing situations and create long-lasting behavior change.

This perspective of addiction as learned is therapeutic because it

- Reduces blame and criticism
- Fosters hope and optimism
- Identifies development and improvement processes.

CBT differs from other models of treatment because it

- Addresses interpretations of events as important cues for compulsive behavior
- Provides structure (every week the counselor devotes a specific amount of time at a specific time in the session to a particular activity)
- Informs and teaches (but is still collaborative).

Integrating MET and CBT

Counselors in the Marijuana Treatment Project (MTP) integrated motivational interviewing skills and techniques (Stephens et al. 2002) as they moved toward building skills and changing cognitions and behavior. Rather than using a traditional cognitive behavioral style of Socratic questioning and didactic teaching, the MTP MET/CBT approach used open-ended questions, gradual presentation of skills, frequent assessment of the client's wish to hear more about a particular skill or concept, and give-and-take in the didactic portion of the sessions. Counselors frequently assessed the client's level of motivation, renegotiating goals and repeating issues when necessary.

The CBT component of BMDC comprises six core elements and four elective skill topics (see exhibit I-2). The sequence of the sessions should be in an order that works best for the counselor and client. The six core skill topics represent the fundamental building blocks for CBT and are recommended for most clients entering treatment. To meet a particular client's needs, a different group of skill topics may be chosen. For example, a client who has experience in similar interventions (e.g., relapse prevention) may not require a review of all the core skill topics. The counselor can select some core skills and add relevant elective materials in developing the session sequence for the client. Another client may have concerns about depression or difficulty regulating moods. The counselor can substitute the elective skill topic on depression in place of a core skill. The counselor and client determine whether and how much the treatment deviates from the established method (10 sessions including 1 assessment, 2 MET, 6 core CBT, and 1 elective).

Tips for the Counselor

- Review relevant sections of the manual before each session.
- Develop a natural style of conveying the material; avoid reading text to clients.
- Maintain a motivational style; use open-ended questions and reflections; and avoid a directive, resistance-building style.
- Encourage involvement and participation by the client.
- Allow time for role plays and feedback.
- Build self-efficacy; help the client identify and acknowledge skills already in use.
- Avoid overwhelming the client; present only one or two new skills per session.
- Remember to take a few minutes to review the between-session exercises at the start of each session.
- Attend to shifts in the client's motivation and readiness for change.
- Explain practice exercises carefully; probe for the client's understanding.

Overview of Session 3: Skill Topic 1, Coping With Other Life Problems

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (all forms are at the end of this section):

- *Problem Checklist* (form 3A)
- *Support Plan* (form 3B)
- Community resource directory (compiled by the program, this should include information on community agencies that the client can access to address concerns listed on the *Problem Checklist*)

Goal for This Session:

- To begin to address the client's non–substance-related problems that can pose obstacles to abstaining from marijuana

Session Outline:

1. Determine whether and when to use psychosocial problemsolving
2. Use the *Problem Checklist* (form 3A) to identify and prioritize psychosocial problems other than substance use
   - Consider information gathered during the assessment
   - Encourage client to be specific about psychosocial problems
   - Have client evaluate the severity of each problem in relation to remaining abstinent
   - Help the client prioritize problems
3. Identify goals and resources
4. Develop a *Support Plan* (form 3B)
5. Discuss implementation issues
   - Use motivational strategies when client demonstrates ambivalence
   - Convey confidence in the client's ability to carry out the *Support Plan*
   - Explore the relationship between the client's psychosocial problems and his or her marijuana use
   - Engage in role plays
6. Help the client identify others who can help with the *Support Plan*
7. Assign between-session exercise
8. Plan to monitor progress
9. Review and conclude session

Session 3 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor uses problemsolving and motivational strategies to teach the client how to use the social service system independently. The counselor helps the client identify problem areas and develop plans to address them. The client builds self-efficacy in recognizing problems and using the social service agencies. The case management model is based on the general model of problemsolving described by D'Zurilla and Goldfried (1971). CSAT's TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998), provides more information on the case management process.

Determine Whether and When To Use Psychosocial Problemsolving

Clients who present for marijuana-dependence treatment often experience problems in other areas. They may be depressed or anxious. They may have lost their jobs or feel they are not doing work they enjoy. They may have health or relationship worries. These difficulties may be related to their long-term marijuana use or may be co-occurring mental disorders.

Although most clients indicate concerns about other life areas, not all want to focus on these problems during treatment. The counselor asks generally about the client's life problems. The counselor and the client decide whether and how much to focus on these other problems, depending on their severity and the degree to which the client wants help with them. If no further attention is warranted, the counselor proceeds to another skill topic. However, the client who indicates significant concerns or who wants help with a non–substance-related problem may benefit from one or more problemsolving sessions.

Use the Problem Checklist *To Identify and Prioritize Psychosocial Problems Other Than Substance Use*

Problems unrelated to marijuana use that may be a hindrance to the client's abstinence efforts include

- Lack of housing or financial support
- Unemployment
- Chronic or acute medical conditions
- Legal problems
- Family or parental pressures
- Social isolation
- Need for transportation and child care.

By reviewing the client's intake or initial session assessments, including the measures of motivation and marijuana-related problems identified on the *Personal Feedback Report* (PFR) (form AS8), the counselor develops a sense of the type and severity of the client's psychosocial problems. Careful assessment requires extensive input from and collaboration with the client.

The counselor and client use the *Problem Checklist* (form 3A) to prioritize problems. The counselor asks the client about each category, encouraging the client to identify each problem as specifically as possible *(I need a job paying at least $9 an hour* rather than *I have no money)*, the effect of the problem on the client's abstinence from marijuana, and a realistic and concrete goal for the problem *(I'll be attending a trade course at the community college by the end of March* rather than *I'll get a job next week)*:

Counselor (C): *You've said that although you're not happy living at your brother's, you recognize that it's a stable place for you for now. However, you'd like to start saving some money for your own place. You mentioned that getting a job is a priority for you; it would keep you occupied and help you get your own apartment. That sounds like a good idea because you think you might use if you have nothing to do all day. How do you see it?*

Bob (B): *That sounds right, but I don't think I can get a job without a car or driver's license.*

C: *Transportation is another issue, and we should add it to our list. How have you been getting to our meetings?*

B: *I get a ride from my sister-in-law on her way to work and take the bus home.*

C*: That's pretty resourceful; how did you set that up?*

B: *I knew the bus lines because I used to work near here.*

C: *It sounds as if you're good at figuring out how to do what you need to do. As we begin to think through how you can reach your goal of getting a job, we'll need to consider how you'll get there. A lot of jobs and training programs are on bus lines, so it may not be difficult. What other difficulties can you foresee that might make it hard for you to reach your goals? You've told me you don't have any medical or legal problems; are there any problems associated with your former marriage or your kids?*

B: *No; I'd like to see the kids more, but that's okay. I guess that's all I can think of, for now.*

C: *Do you think your relationship with your kids is connected with your marijuana use?*

B: *I think I'd be a better dad and see them more often if I wasn't smoking.*

C: *So it sounds as if that's an important goal for you and another reason for stopping. You may become aware of other problems as we go on; we can talk about them and how they may be associated with your marijuana use as they come up.*

or

C: *During your initial assessment, you noted housing, transportation, and a family medical concern as problems.*

Shirley (S): *I'm concerned about my older sister. She has bipolar disorder and whenever she goes off her medication, my husband and I spend a couple of hundred dollars to get her back to a psychiatrist and on medication. We have only one car, so we argue about who will use it. Now that I've started student teaching, I need the car every day. It was difficult for me to get here today because my husband was late.*

C: *As you think about these three areas, how would you prioritize them? Which seems more pressing for you?*

S: *Right now transportation is a top priority, then my sister, and then a new house. We're going to see whether I get a teaching job this fall before we start looking for a house.*

C: *Let's start with transportation. What would you like to happen and when?*

S: *We don't have the money for a second car right now.*

Identify Goals and Resources

The counselor and client specify goals for improving the client's situation. The program's community resource directory should describe services offered, eligibility, and contact personnel at community agencies. The directory should include information about housing assistance, vocational training, financial assistance, legal services, medical services, mental health services, parenting and childcare resources, support groups, homeless shelters, women's shelters, emergency services, food assistance, education and training resources, unemployment counseling, rape crisis centers, and transportation resources.

The counselor and client use the directory to identify relevant resources, determine whether the services offered match the client's goals, and devise a plan for contacting the agency or service (e.g., who will do the contacting, what the specific goal of the contact is, when contact will be made). Because a major goal of this session is to build client self-efficacy in negotiating the social service system, the counselor encourages the client to contact the agency. If the client does not have the skills to make initial contacts effectively, the counselor and client role play a contact with an agency. If the agency requires that the counselor make the initial contact, he or she makes the call during the session to model effective negotiation skills.

The counselor helps the client transform his or her goals into a plan for obtaining services, and together they plan the steps:

C: *So, although you have a problem, you're not sure of possible solutions?*

S: *The solution would be more money, and we don't have that right now!*

C: *Money would help. But did you know the county offers discounted bus fares for students?*

S: *No; I was wondering about that because the bus runs right by my school.*

C: *I have a book here with the phone number to call for information. Do you want to call?*

Develop a Support Plan

Once the *Problem Checklist* is completed, goals have been developed, and the resource list has been reviewed, the counselor and client work on the *Support Plan* (form 3B)—a concrete strategy outlining how the client will follow through on reaching goals. For each goal, the *Support Plan* includes whom (or which agency) to contact, when to make the contact, what services or support to request, and what the outcome was. The *Support Plan* is a record of the client's efforts to obtain services and bolsters his or her self-efficacy:

S: *I'd like to know how much the bus pass costs and what time the bus runs. I wouldn't need it every day; maybe 2 or 3 days a week. Can we call now?*

C: *Sure. Let's write down on the Support Plan what you would like to see happen. First, we need to find out how much a bus pass costs with the student discount. Second, we need the bus route and schedule between your home and the school. We need to know whether the bus schedule fits with your school schedule. Here's the phone. I'll read you the number.*

Discuss Implementation Issues

The client may be ambivalent about addressing psychosocial problems that are barriers to abstinence. He or she may question whether he or she has the skills needed, wonder whether change may bring on new challenges, and question changing the status quo. The counselor remains alert to signs of client ambivalence.

The stages-of-change model is applicable to acquiring psychosocial support (see sessions 1 and 2). For example, some clients may be precontemplators, unaware of barriers affecting their life; others may be contemplators, aware of barriers but not sure they are ready to overcome them; and others may be ready to engage with resource providers.

The counselor uses the following motivational strategies to encourage the client to address psychosocial problems other than marijuana:

- **Elicit self-motivational statements**

  C: *Tell me how not having a job has affected you.*

  C: *You've said it's tough not having a safe place to live and that it makes it harder to stop smoking, but you haven't convinced me that you're ready to do something about it. Should we go ahead with our plans?*

- **Listen with empathy**

  C: *It sounds as if you're worried about taking all this on at once.*

  C: *You feel not seeing Jerry as much would be an important step forward, but you worry about not seeing a friend you've been close to for a long time.*

- **Roll with resistance**

  C: *You're not sure you're ready to spend time finding a new place to live.*

  C: *I think you're jumping ahead. We're not talking about moving right now; we're just looking at how living in your current neighborhood may be interfering with your goal of quitting marijuana use.*

- **Communicate free choice**

  C: *It's up to you what to do about this.*

  C: *You can take this on now or wait for another time.*

- **Review consequences of action and inaction**

  C: *What do you see happening if you don't see a doctor?*

  C: *It sounds as if you're concerned about calling your probation officer right now; what do you think will happen if you don't?*

Throughout the sessions, the counselor praises all the client's efforts to carry out the *Support Plan*, even small steps. The counselor conveys confidence that the client has the resources and skills to carry out the plan and obtain services, during treatment and after treatment:

C: *I'm impressed that you arranged a place at Transitional Housing. You questioned whether you could handle the steps, but you hung in there. You were persistent when you were put*

on hold several times, and you kept rescheduling those interviews until you got them. It wasn't easy, but you made it happen. How do you feel about how you handled it?

B: *It wasn't easy, and once or twice I felt like telling them off, but I just kept telling myself I need a drug-free place to live and that I could do it.*

C: *You sound proud of yourself, and your pride is well deserved. Knowing how to contact the social service system is an important skill, and you're getting better at it. Have you thought about your next step?*

The counselor encourages the client who lacks confidence and communication skills to make initial phone calls during the sessions; the counselor provides support and coaching if necessary. After each call, the counselor and client talk about the call, and the counselor praises the client's efforts, offers constructive criticism, and reviews the next steps in the client's change plan.

A key strategy in this session is exploring the relationship between other life problems and marijuana use. What are their roles in the client's marijuana use, and how are they frustrating his or her efforts to become involved in treatment?

C: *You've told me your concerns about problems you're having, including not having a place of your own or a job, and your probation officer is concerned about these problems, too. How do you see these problems making it harder for you to stop smoking?*

B: *Well, I'm staying at Jerry's, and he's always smoking. I don't have anything to do all day, and time moves when you're partying. I wasn't smoking as much when I was working. The thing is, I don't know anybody who doesn't smoke.*

C: *So it sounds as if finding a place to live where you won't be with people who smoke and getting a job will help you reach your goal of stopping smoking. Meeting some new people who don't smoke might help also. These are important goals. Let's talk about how you might tackle these problems. Are you concerned about other problems that might make it hard to stop?*

If the client lacks assertiveness skills, the counselor engages the client in role plays of contacts with agency representatives. To break the ice, the counselor plays the person seeking service and the client plays the agency representative. After the initial role play, the counselor comments on the skills that were demonstrated (e.g., assertiveness, asking for a specific service, eliciting information, avoiding arguments). Then the counselor plays the agency representative and the client plays the person requesting service. Afterward, the counselor points out effective behavior and provides constructive criticism:

C: [A person requesting services] *Hello. My name is Shirley, and I'm calling because I would like information about your center and how I might set up an appointment with a family counselor for me, my husband, and our children.*

S: [As agency representative] *Well, we have a long waiting list. You might want to call back next month.*

C: *Okay, I understand that your program is filled, but could you direct me to another family counseling center that might have a shorter wait?*

Help the Client Identify Others Who Can Help With the Support Plan

Because the counselor's role is helping the client identify barriers to addressing marijuana use, formulating a *Support Plan* (form 3B), and helping the client implement the plan, it may be useful to identify others who can help the client carry out the *Support Plan* and ways they can help (e.g., accompanying the client to appointments, helping with some of the legwork, helping in negotiating the system or with transportation or child care, providing financial assistance). The counselor adds the names of these people to the *Support Plan*.

The client may have withdrawn from friends and family who do not use drugs, reducing his or her social circle to only people who use drugs. As the client recognizes the importance of reducing contacts with people who use drugs while trying to overcome dependence, he or she may fear social isolation when he or she needs others' support the most. The counselor explores the nature and extent of the client's social network and suggests expansion of that network as a treatment goal.

Assign Between-Session Exercise

The counselor asks the client to select a problem to work on during the week. The client should complete a *Support Plan* for the problem and be prepared to discuss his or her efforts to solve the problem at the beginning of the next session.

Plan To Monitor Progress

Even though the client is responsible for following the *Support Plan* and obtaining services, the counselor monitors all efforts to complete the plan; these efforts should be discussed in every session during the check-in phase. The counselor asks about the client's efforts to implement the *Support Plan* since the preceding session. A portion of the closing of the session should be devoted to reviewing what the client will do to implement the *Support Plan* during the coming week.

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor explains that the client will report back on his or her efforts to complete the plan at the next session.

Overview of Session 4: Skill Topic 2, Understanding Marijuana Use Patterns

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (all forms except form 1A, which is in Section V, are at the end of this section):

- *Marijuana Use Self-Awareness Record* (form 4A)
- *Learning New Coping Strategies* (form 1A)
- *Future-Self Letter* (form 4B)
- *Pleasant Activities* (form 4C)
- *Relaxation Training* (form 4D)
- *Boredom Management* (form 4E)

Goals for This Session:

- To introduce the client to the reasoning behind coping skills training
- To examine the client's high-risk situations and coping strategies

Session Outline:

1. Explore the development of addictive patterns
   - Give examples of how marijuana can change how one feels; ask client how these examples fit with his or her experience
   - Give examples of environmental triggers for use; ask client for other triggers he or she has experienced
   - Give examples of beliefs or automatic thoughts people may have about marijuana; use examples provided by the client; and ask the client for more examples
   - Suggest that the client start the process of change by understanding his or her behavior; ask, *Does this make sense to you?*
2. Assess high-risk situations
   - Ask client about
     - Typical use situations (places, people, activities, time, days)
     - Triggers for use
     - A recent use situation
     - Thoughts and feelings at use times (tense, bored, stressed, etc.)
   - Complete *Marijuana Use Self-Awareness Record* (form 4A) and summarize the list
3. Build coping strategies
   - Emphasize the importance of coping strategies
   - Reintroduce *Learning New Coping Strategies* (form 1A)
   - Ask client to identify strategies he or she has tried and those that might work best

4. Assign between-session exercises
   - Give client a blank copy of the *Marijuana Use Self-Awareness Record* (form 4A) to document episodes of craving/desire between sessions
   - Choose additional assignments based on the client's current needs
     - Writing a *Future-Self Letter* (form 4B)
     - *Pleasant Activities* (form 4C)
     - *Relaxation Training* (form 4D)
     - *Boredom Management* (form 4E)
5. Review and conclude session

Session 4 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor draws on information from previous sessions to increase the client's understanding about use patterns.

Explore the Development of Addictive Patterns

The counselor asks the client to look closely at his or her behavior, environment, and beliefs to identify addictive patterns:

Counselor (C): *We think of repeated marijuana use as learned behavior. When people start to use marijuana a lot, they learn that it changes the way they feel. For example, some people use it like a tranquilizer to help them cope with stressful situations. Some use it when they feel blue. Others expect it to enhance positive feelings. Some think it makes them more confident. And some use it to avoid thinking about troublesome things. How does that fit with your experience?* [Waits for answer.]

C: *After a while, things in the environment can trigger use, sometimes without your even realizing it. The environment can trigger cravings. Things in the environment that can trigger use include seeing or smelling marijuana, being around people who are smoking, or being in stressful situations. During the assessment session, we talked about the connection you've noticed between getting paid on Fridays and buying pot. Are there other connections like that for you?*

C: *People often develop beliefs about marijuana and their using. These are ideas or "automatic thoughts" you've come to believe about you and your marijuana use. I've heard you say things in previous sessions like, "I can't be creative or work effectively without it," "I can't take the way I feel when I've tried to quit," "I need to change, but it's not worth the effort." What other beliefs do you have about you and marijuana?*

C: *Marijuana can change the way a person feels, acts, and thinks. To help you avoid or cope with the situations in which you smoke and to help you find things you can do instead of smoking, let's start by working on understanding your behavior. Does this make sense to you?*

Assess High-Risk Situations

The counselor explains that marijuana use behavior is learned over time. The client's understanding of his or her use patterns can help the client change those patterns. Understanding high-risk situations can help the client avoid or cope with those situations:

C: *If using marijuana changes the way a person acts, thinks, and feels, it's helpful to begin by identifying use patterns and habits. Once your patterns are identified, you may find it easier to change your behavior. You can find ways to cope with your high-risk situations without using. Change involves learning specific skills and strategies. Once you know about the situations and problems that contribute to your using marijuana, you can look for other ways to handle those situations. What do you think about that?*

The counselor focuses on the client's behaviors and high-risk situations:

C: *In what situations do you use marijuana (e.g., places, people, activities, specific times, days)?*

C: *What are your triggers for using (e.g., when you're in a social situation, when you've had a tense day, when you're faced with a difficult problem, when you want to feel relaxed)?*

C: *Can you describe a recent situation when you used (e.g., a relapse story)?*

C: *Can you remember your thoughts and feelings at the time you used (e.g., tense, bored, depressed, stressed, overwhelmed, angry)?*

C: *What were the consequences of using?*

The counselor asks the client about marijuana use behavior using motivational interviewing techniques (e.g., reflection, expressing empathy) while finding out important information about the client's use environment:

C: *In what situations do you find yourself smoking?*

Doug (D): *When things get hectic at home. Between my wife and my son, it seems as if everyone is out to get me. When I smoke, I can cope with them.*

C: *Smoking helps you cope with stress at home. Are there other situations when you smoke?*

D: *Not right now. When I go home, I should be able to relax, but with all the nagging, I end up smoking to escape.*

C: *You want your home to be peaceful, but conflicts over your smoking push you to smoke.*

D: *Yeah; sounds crazy, doesn't it?*

C: *Your situation is difficult. Things you identify that lead you to smoke are called triggers. You've said that conflicts at home trigger you to smoke. What are your thoughts and feelings during times of conflict at your house, right before you light up?*

D: *I'm thinking that if everyone would get off my back, I might be able to quit smoking. But they don't, and it's the only way I know how to relax.*

C: *You find yourself in a bind. Let's use the* Marijuana Use Self-Awareness Record [presents form 4A] *to list the things we're talking about. You said smoking marijuana helps you relax. What else does it do for you?*

D: *It helps me sleep. When I don't get high, it's hard getting to sleep. I used to enjoy the high a lot more than I do now. I keep smoking, but I don't even get that high anymore.*

C: *Sounds as if you're listing the negative parts of smoking. Are there others?*

Together the counselor and client fill out the *Marijuana Use Self-Awareness Record* (form 4A).

Build Coping Strategies

The counselor emphasizes the importance of coping strategies:

C: *We've talked about your high-risk situations for triggering marijuana use. This is important because many people are unaware of how they put themselves at risk for using. Now we'll focus on coping with these situations in ways that will help you resist the urge to smoke. You've already read the* Learning New Coping Strategies [presents form 1A]*. Let's take a few moments to go through it and identify the strategies you've tried and others that might work. Remember, some strategies involve things you can do or specific actions you can take, some involve ways of thinking, and some involve other people or your surroundings.*

The counselor records responses on the *Marijuana Use Self-Awareness Record* (form 4A) and summarizes the list. The counselor follows up by asking for other examples.

Assign Between-Session Exercises

The counselor gives the client a blank copy of the *Marijuana Use Self-Awareness Record* and asks the client to document episodes of craving or desire for marijuana between this session and the next one. In addition, the counselor chooses an appropriate assignment from among the following and reviews the instructions with the client:

- Write a *Future-Self Letter* (form 4B)
- Increase your *Pleasant Activities* (form 4C)
- Practice *Relaxation Training* (form 4D).

If struggling with boredom is a particular problem, the counselor gives the client the *Boredom Management* handout (form 4E).

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor explains that the client will report back on his or her efforts to complete the between-session exercises at the next session.

Overview of Session 5: Skill Topic 3, Coping With Cravings and Urges To Use

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (all forms are at the end of this section):

- *Coping With Cravings and Urges* (form 5A)
- *Urge Surfing* (form 5B)
- *Daily Record of Urges To Use Marijuana* (form 5C)

Goals for This Session:

- To enhance the client's understanding about cravings and urges for marijuana use
- To identify specific triggers or cues for cravings (see Carroll 1998)
- To review and practice specific skills for addressing cravings

Session Outline:

1. Give reasons for focusing on cravings
   - Provide basic information about the nature of cravings
     - — Cravings are experienced most often early in abstinence but can occur weeks, months, even years later
     - — Cravings may feel very uncomfortable but are a common experience
     - — An urge to smoke does not mean something is wrong
   - Give client *Coping With Cravings and Urges* (form 5A)
2. Identify cues for cravings
   - Give client examples of common cues
     - — Exposure to marijuana or paraphernalia
     - — Seeing other people using
     - — Contact with people, places, times of day, or situations associated with using
     - — Particular emotions and physical feelings
3. Discuss strategies for coping with triggers
   - Getting involved in a distracting activity
   - Talking it through
   - Urge surfing (*Urge Surfing*, form 5B)
   - Delaying decisions
   - Using imagery
   - Challenging and changing thoughts
   - Using self-talk
4. Complete exercises
   - Make a list of craving triggers
   - Make a plan for managing craving

5. Assign between-session exercises
   - Encourage client to review material on handouts before the next session
   - Encourage client to practice urge surfing
   - Complete *Daily Record of Urges To Use Marijuana* (form 5C)
6. Review and conclude session

Session 5 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor supports the client's experience and efficacy in making desired changes.

Give Reasons for Focusing on Cravings

The counselor gives the client *Coping With Cravings and Urges* (form 5A) and explains the importance of recognizing cravings:

Counselor (C): *Cravings often are experienced when a person first tries to quit, but they may occur weeks, months, even years later. Cravings may feel uncomfortable, but they are common experiences. An urge to smoke doesn't mean something's wrong. Many people learn to expect cravings on occasion and how to cope with them.*

Things that remind you of using marijuana can trigger urges or cravings. Physical symptoms include tightness in the stomach or feeling nervous throughout the body. Psychological symptoms include thoughts about how using marijuana or drugs feels, recollections of smoking marijuana, developing plans to get marijuana, or feeling that you need marijuana.

Cravings and urges usually last only a few minutes or at most a few hours. Rather than increase until they become unbearable, they usually peak after a few minutes and then die down, like a wave. Urges become less frequent and less intense as you learn more methods for coping with them.

Identify Cues for Cravings

The counselor talks about triggers or cues:

C: *It's important to learn how to recognize triggers so you can reduce your exposure to them. Common triggers include*

- *Exposure to marijuana or paraphernalia*
- *Seeing other people using*
- *Contact with people, places, times of day, and situations associated with using (such as people you used with, parties, bars, weekends)*
- *Particular emotions (such as frustration, fatigue, feeling stressed), even positive emotions (elation, excitement, feelings of accomplishment)*
- *Physical feelings (feeling sick, shaky, tense).*

Some triggers are hard to recognize. Self-monitoring can help you identify them.

The easiest way to cope with cravings and urges is to minimize their likelihood of occurring. You can reduce your exposure to triggers by getting rid of marijuana in the house, not going to parties or bars, and limiting contact with friends who use.

Discuss Strategies for Coping With Triggers

The counselor presents several coping strategies:

C: *Many times cravings can't be avoided, and it becomes necessary to cope with them. Here are some possible strategies for coping with craving:*

Get involved in a distracting activity. *Reading, engaging in a hobby, calling a friend, going to a movie, and exercising (jogging, biking) are good examples of distracting activities. Once you get interested in something else, you'll find that the urges go away in no time.*

Talk it through. *Talking to your supporter or a friend or family member can pinpoint the source of the craving and help relieve the feeling. It also can restore honesty in your relationship.*

Urge surfing. [Gives client *Urge Surfing* handout (form 5B) and reads sheet aloud.]

Delay the decision to use. *Most urges to use are like waves—they build to a peak and then dissipate. If you wait 15 minutes, the wave will pass. Try imagining you're a surfer riding the wave of craving until it subsides, or use another image that works for you.*

Use imagery. *If you feel as though you are about to be overwhelmed by urges to use, imagine scenes that portray those urges as storms that end with calmness, mountains that can be climbed, or waves that can be ridden. Everyone can find an image to maintain control until the urge peaks and then dissipates. Some people imagine being a warrior who can defeat urges as if they were an enemy or an explorer who can slice through tropical underbrush and carve out a trail. Images can be made vivid by using relaxation techniques and all the senses (e.g., seeing the thick green jungle, hearing the blade swishing through the leaves, smelling the tropical plants). Photographs of loved ones also can distract you.*

Challenge and change your thoughts. *When experiencing cravings, many remember only the good effects of using and forget the negative consequences. You may find it helpful to remind yourself of the benefits of not using and the negative consequences of using. Remind yourself that you won't feel better if you just get a little high and that you lose a lot by using. It's helpful to have these benefits and consequences listed on a small card to carry around.*

Self-talk. *People constantly think about their actions and things that happen to them. These thoughts can influence strongly the way you feel and act. What you tell yourself about your urges to use affects how you experience and handle them. Your self-talk can be used to strengthen or weaken your urges. Making self-statements is so automatic you may not notice it. For example, a self-statement that is automatic for you may be, "I am a skilled photographer" or "I have no willpower." Hidden or automatic self-statements about urges can make them hard to handle. ("I want to get high now. I can't stand this. The urge is going to get stronger and stronger until I use. I won't be able to resist.") Other types of self-statements can make the urge easier to handle. ("Even though my mind is made up to stay clean, my body is taking longer to learn this. This urge is uncomfortable, but in 15 minutes or so, I'll feel like myself again.") We will discuss these automatic thoughts more in the next session.*

There are two basic steps in using self-talk constructively:

1. *Pinpoint the things you tell yourself that make it harder to cope with an urge. One way to tell whether you're on the right track is when you hit on a self-statement that increases your discomfort, for example, "I will never be able to withstand this urge." That discomfort-raising self-statement is a leading candidate for challenge.*
2. *Use self-talk constructively to challenge the statement. An effective challenge makes you feel better (less tense, anxious, panicky) even though it may not make the feelings disappear entirely. The most effective challenges are ones tailored to specific self-statements. Listed below are some challenges that people find useful:*

   - ***What is the evidence?*** *What is the evidence that if I don't get high in the next 10 minutes, I'll die? Has anyone ever died from not using? What's the evidence that people recovering from a marijuana problem don't have the feelings I'm having? What is the evidence that I'll never improve?*
   - ***What's so awful about that?*** *What's so awful about feeling bad? Of course I can survive it. Who said that abstinence would be easy? What's so terrible about experiencing an urge? If I hang in, I'll feel fine. These urges are not like being hungry or thirsty; they're more like a craving for a particular food or an urge to talk to a particular person—they'll pass.*
   - ***I'm a human being and have a right to make mistakes.*** *Maybe I worry about being irritable, preoccupied, or hard to get along with. What's so bad about that? We all make mistakes and in a situation that's complicated, there is no "right" or "perfect" way to get along.*

Some of these strategies will be necessary or helpful only initially to distract yourself from persistent urges; in the long run, you'll have an easier time if you replace the thoughts with other activities. After a while, abstinence will feel more natural; the urges will diminish in intensity and will come less often. You will also know how to cope with them.

In the example below the counselor and client discuss craving triggers and self-talk strategies:

C: *You identified one of your strongest triggers as seeing other people smoking, especially family members. Let's try to pinpoint exactly what's going on.*

Shirley (S): *I feel that if I don't smoke with some family members, they might think I'm above them. They already make fun of me, calling me the college girl, and I want to fit in.*

C: *You're sensitive to your family members and concerned that they'll think you're trying to be better than they are by not smoking. What is the evidence that this will happen?*

S: *Well, I guess it's more of a fear than a fact. I really do love them and know that they love me. But I don't know how they would respond.*

C: *What thoughts have you had about telling them?*

S: *I almost told my uncle the other day when he lit up. But then I ended up smoking, and I just couldn't.*

C: *You realize that once you get high, it's difficult to make changes.*

S: *I've been thinking that I need to tell them when there's no chance that we would be smoking. But I dread it!*

C: *What are some other ways you might let them know?*

Complete Exercises

The counselor introduces the following exercises:

C: ***Make a list of craving triggers.*** *Circle the triggers that you can avoid or to which you can reduce your exposure (such as having marijuana in your home).*

Make up a craving plan. *Pick two or three of the general strategies that were discussed and plan how to put them into practice if you experience an urge. Cravings can come when you least expect them! For example, if you think distracting activities would be helpful, which activities would you pick? Which are available? Which take preparation? If you were feeling a craving, whom would you call? If you haven't tried urge surfing before, practice with me before trying it when facing an urge.*

Assign Between-Session Exercises

The counselor encourages the client to review the material on the handouts between sessions and to practice urge-surfing techniques. The counselor also gives the client a blank *Daily Record of Urges To Use Marijuana* (form 5C), shows the client a completed form (exhibit VI-I) as an example, and asks him or her to fill it out during the week.

Exhibit VI-1. Daily Record of Urges To Use Marijuana (Sample)

Date	Situation (include thoughts and feelings)	Intensity of Cravings(1–100)	Coping Behaviors Used
5/16/03	Was feeling stressed. Had a disagreement with my boss.	75	Shut myself in office and breathed deeply to relax. Felt better after 20 minutes.
5/17/03	Restless at bedtime. Trouble getting ready for bed.	60	Took a hot shower, listened to relaxing music. Shower was better than music.
5/18/03	Went dancing at club where I always used to get high.	80	Hung around with "clean friends." It was a close call. Should have prepared in advance.
5/19/03	Payday. Bob wanted to party after work.	65	Suggested we go for coffee instead. Bob agreed! Boy—was I surprised!

Source: Monti et al. 1989.

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor explains that the client will report back on his or her efforts to complete the between-session exercises at the next session.

Overview of Session 6: Skill Topic 4, Managing Thoughts About Marijuana Use

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Material (form is at the end of this section):

- *Managing Thoughts About Marijuana* (form 6A)

Goal for This Session:

- To identify and learn to cope with automatic thoughts associated with marijuana use

Session Outline:

1. Reinforce that thoughts about marijuana use are normal
2. Identify thought patterns associated with use
3. Discuss automatic thoughts and strategies for coping
   - Explain situations that may trigger automatic thoughts
     - Nostalgia
     - Testing control
     - Crisis
     - Feeling irritable when abstinent
     - Escape
     - Relaxation
     - Socialization
     - Improved self-image
     - To-hell-with-it thinking
     - No control
4. Explore conceptual difficulties
   - Review material and probe for client's understanding of basic concepts
   - Use illustrations and examples
   - Walk client through a using episode to understand thought processes
5. Develop skills for coping with automatic thoughts
   - Explain three general principles for coping with thoughts about using
     - A commitment to abstinence
     - Recognition of drug-related thoughts
     - Need for time to master automatic thoughts
   - Describe specific strategies for managing thoughts about using; review *Managing Thoughts About Marijuana* (form 6A)
6. Practice skills for coping with automatic thoughts
   - Demonstrate self-talk

- — State a using thought and follow it with a challenging statement
- — Make eye contact and speak clearly and confidently
- — Repeat with other examples as necessary

• Have client practice with one of his or her using thoughts

- — Support client's phrasing of both thought and challenge
- — Encourage client to be specific
- — Identify any problems in client's practice and ask client to try again

7. Assign between-session exercises

8. Prepare for end of treatment

9. Review and conclude session

Session 6 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor helps the client manage thoughts about marijuana use.

Reinforce That Thoughts About Marijuana Use Are Normal

The counselor discusses the relationships among thoughts, feelings, and using marijuana:

Counselor (C): *For people who have smoked marijuana for a long time, thoughts about using are normal; almost anyone who stops using thinks about starting up again. Thinking about using is not a problem provided you don't act on those thoughts. You may feel guilty about thoughts, and you may try to get them out of your mind. This skill topic will help you learn new ways to manage your thoughts before you slip. Sometimes the thoughts are obvious, but sometimes they creep up on you without notice.*

Identify Thought Patterns Associated With Use

The counselor explains how negative thinking relates to marijuana use:

C: *People who used marijuana need to be aware of a state of mind that predisposes them to a relapse. This state of mind is characterized by dangerous attitudes and thought processes and is called "negative thinking." Negative thinking is dangerous because it induces people who have used marijuana to let down their guard (decrease vigilance). The thought itself isn't the problem; it's how people cope with their thoughts. If people learn to dismiss this thinking from their minds whenever it appears, recognize it for what it is, or counter it with a challenging thought, it need not lead to a relapse. You can learn strategies for coping with these thoughts.*

Discuss Automatic Thoughts and Strategies for Coping

The counselor describes situations that may trigger automatic thoughts or thoughts that could lead to a lapse:

C: ***Nostalgia.*** *Some people who formerly used marijuana remember using nostalgically, as if marijuana were an old friend. For example, "I remember the good old days when I'd go out dancing and smoke a few joints."*

Testing control. *After a period of abstinence, people in recovery may become overconfident. For example, "I bet I can use tonight and go back on the wagon tomorrow morning." Curiosity also can be a problem: "I wonder what it would be like to get high again?"*

Crisis. *A person may respond to stress by saying, "I can handle this only if I'm high" or "I went through so much, I deserve to get high" or "When this is over, I'll stop using again."*

Feeling irritable when abstinent. *Some people find new problems arise after they become abstinent and think using will solve these problems. For example, "I'm short-tempered and irritable around my family—maybe it's more important for me to be a good-natured parent and spouse than it is to stop using right now" or "I'm no fun to be around when I'm not using; I don't think I should stop because if I do, people won't like me as much."*

Escape. *Individuals want to avoid unpleasant situations, conflicts, or memories. Failure, rejection, disappointment, hurt, humiliation, embarrassment, and sadness tend to demand relief. People get tired of feeling hassled, upset, and lousy. They want to get away from it all and from themselves. They seek numbness and the perceived absence of problems.*

Relaxation. *Thoughts of wanting to unwind are normal, but sometimes people look for a shortcut, trying to unwind without doing something relaxing. The individual may choose the more immediate route through marijuana.*

Socialization. *This overlaps with relaxation but is confined to social situations. Individuals who are shy or uncomfortable in social settings may feel they need a social lubricant to decrease awkwardness and inhibitions.*

Improved self-image. *This situation involves a pervasive negative view of oneself and associated low self-esteem. When individuals become unhappy with themselves, feel inferior to others, regard themselves as lacking essential qualities, feel unattractive or deficient, or doubt their ability to succeed, they begin to think of using marijuana again because using previously may have provided immediate, but temporary, relief from these painful feelings.*

To-hell-with-it thinking. *During the weeks and months of trying to be abstinent, a person may become discouraged and think to hell with it. Thinking this way might result from a disappointing experience, feeling tired from coping with temptations, or other difficult situations.*

No control. *The attitude of being unable to control cravings ensures relapse. Individuals give up the fight, conceding defeat before attempting to resist marijuana use; they may feel out of control in other aspects of their lives as well. Marijuana is considered a viable option. This attitude differs from the to-hell-with-it attitude in which individuals do not necessarily feel powerless; they just don't want to continue abstaining.*

Explore Conceptual Difficulties

A client may have difficulty understanding the concepts of *cognitive analysis* and *restructuring*. If a concept is not understood, then the benefits of cognitive coping skills are lost. The counselor

probes for the client's understanding before moving on to the next concept. Using illustrations and examples helps convey the basic principles.

Initially a client may be unaware of the thoughts and feelings that precede decisions to use marijuana. He or she may be unaware of triggers and state, *I just start using, that's all.* The client may admit that usually some external force occurs immediately before use but cannot remember what it is. The client denies personal responsibility for actions and attributes behavior to forces beyond his or her control, making it difficult for the client to initiate appropriate coping skills.

To help the client grasp cognitive concepts, the idea of "slowing down the action" (as in an instant replay or a slow-motion film sequence) of the thought process is useful. The counselor assists the client in breaking down the sequence of thoughts and feelings that lead to particular actions. He or she learns to observe, for example, that a tense interaction with a colleague may lead to feelings of frustration and to thoughts about not being good enough (e.g., smart, competent, or skilled enough), which lead to thoughts about wanting to use marijuana. Once the client can analyze the series of thoughts that might have led to a previous relapse, the notions of self-motivating (or self-awareness) and of modifying one's thoughts (cognitive restructuring) can be introduced. The goal is to make the client aware of his or her thought processes and enable the client to replace using thoughts with coping thoughts that enhance abstinence:

C: *Try to identify your thoughts about resuming marijuana use and rationalizations for using. What thoughts preceded your last using episode after a period of abstinence? What thoughts about marijuana seem to be the most frequent or strongest? Under what circumstances do these resumption thoughts tend to occur? Although this activity may feel strange, like most skills, it becomes easier with time.*

Develop Skills for Coping With Automatic Thoughts

The counselor helps the client identify automatic thoughts and reviews some of the techniques used in previous sessions:

C: *Everyone trying to stop marijuana use has thoughts about using. It's not the thought that creates the problem but how people cope with it. If you learn to recognize these thoughts and counter them with contrary thoughts, they need not lead to a lapse.*

The three general principles for coping effectively with thoughts about using are

1. *It's easier to choose to remain abstinent and not to give in to persistent thoughts if you are committed firmly to quitting.*
2. *It's easier to challenge drug-related thoughts and change them if you are aware of them.*
3. *This coping skill takes a long time to master; these thoughts can return months and years after you stop using.*

The counselor reviews strategies for managing thoughts about using marijuana and shows the client *Managing Thoughts About Marijuana* (form 6A):

C: ***Challenge them.*** *Use other thoughts to challenge the resumption thoughts. For example, "I cannot get a little high without increasing my risk of using more" or "I don't have to use marijuana to unwind after work; I can use relaxation exercises" or "I can have good times without marijuana; it may feel strange at first, but in time I'll feel more comfortable."*

An important aspect of challenging thoughts about using (as well as forms of thought distraction and substituting behaviors incompatible with using) is to avoid visualizing what you are not going to do and instead picture a behavior that you will do. You might try developing a mental picture of the new behavior when the old habit pops into mind.

List and recall benefits of not using. *Thoughts about the personal benefits of abstinence can weaken excuses for using. Benefits to think about include better physical health, improved family life, job stability, more money for recreation and paying bills, increased self-esteem, and self-control. It is important to pay attention to these positive aspects and the progress you're making; don't focus on what you're giving up. Carry a card with you listing the benefits, add items as you think of them, and review them regularly.*

Recall and list unpleasant using experiences. *Recall the pain, fear, embarrassment, and negative feelings associated with using marijuana. Make a list of unpleasant experiences, such as memory problems, lack of motivation, procrastination, arrests, withdrawal, paranoia, and sleep disturbances on the back of the card that lists the benefits of abstinence. Read the card regularly. Counteract the positive thoughts you have about using with the negative aspects of using and the benefits of abstinence. Visualize the possible using episode to the end and include all the detrimental consequences that occur with using marijuana.*

Find distractions. *Think about something pleasant, like holiday plans, vacation spots, loved ones, relaxation, or hobbies. Focus on a task you want to get done.*

Promote self-reinforcement. *Remind yourself of your success—for example, 2 weeks of abstinence, involvement in treatment, staying in the treatment program.*

Leave or change the situation. *Try a different activity, such as a hobby or physical exercise.*

Call your supporter or a friend.

Use self-talk. *As mentioned in session 5, self-talk refers to constructive things you can say to yourself that replace negative thoughts. We talk to ourselves all the time. Our thoughts have a powerful effect on how we feel and act and on our decisions. One way to be sure negative thoughts don't sabotage your effort to quit is to learn how to recognize them and challenge them effectively. Self-talk is an effective way of coping with thoughts that make staying away from marijuana difficult.*

Practice Skills for Coping With Automatic Thoughts

The counselor and client practice self-talk:

C: *Let's practice self-talking in response to concerns about quitting. We'll choose a general concern about quitting to work on. Then you'll do two things:*

1. *State the concern in your own words, using an "I" statement.*
2. *After stating the concern, follow it with a challenging statement. Again, use the pronoun "I" when making a challenging statement, and say it forcefully.*

The counselor illustrates how to self-talk by focusing on a particular automatic thought that might trigger marijuana use *(e.g., I guess I wasn't as dependent on marijuana as I thought)*. The counselor states that thought and follows it with a challenging statement:

C: ***1. Automatic thought.*** *Quitting marijuana was easier than I thought. I must not have been dependent on it in the first place.*

2. Challenge. *I must be crazy. What am I saying? Quitting hasn't been easy. I had the urge to smoke all the time until the last few days. If I weren't dependent on it, I could have quit long ago. I'm just missing the feeling of being high and starting to talk myself out of quitting. I think I'll do something else.*

When conducting the demonstration, the counselor makes eye contact, speaks clearly and confidently, and repeats the demonstration if necessary. After the counselor gives a few demonstrations, the client practices using any concerns he or she has. Other examples of automatic thoughts include *I'm not feeling that much better now that I've quit* or *I bet I can smoke once in a while*.

It is important to support the client's phrasing of the automatic thoughts and the challenges. The counselor encourages the client to be specific *(What do you mean by "No one cares whether I smoke or not?")*, deliver responses as if the situation were real, and use the first person. If the client gives an unsatisfactory response, the counselor specifies the problem (e.g., not the first person, not specific in the challenge, not said in a forceful tone) and asks the client to try again. The counselor gives constructive feedback and avoids judgments or disapproval.

The following factors contribute to the client's ability to formulate a positive response although not all need to be present all the time:

- Acknowledgment of negative or ambivalent feelings
- Reminder of the positive side (e.g., motivation and commitment, long-term positive outcomes, enhanced self-esteem, improved health)
- Specific positive alternatives
- Humor
- Absence of self-condemnation
- Self-reinforcement or self-appreciation.

Miguel (M): *Sometimes, I just want to smoke. It's easy to forget why I wanted to quit.*

C: *It gets easier with experience. You are changing a habit that was formed over many years and are finding it difficult at times. People need to remind themselves of how hard that can be. Let's go over the skills that may help you and see whether you think they will work.*

Assign Between-Session Exercises

At the end of the session, the counselor explains the between-session exercises on *Managing Thoughts About Marijuana* (form 6A). To complete this exercise, the client writes out lists of

- 5 to 10 benefits of not using
- 5 to 10 negative consequences associated with using
- 5 to 10 stumbling blocks or high-risk situations for maintaining abstinence.

The client uses this information (the benefits of abstinence and the negative consequences of using) to rate his or her commitment to quitting. The client's perceived level of commitment can range from 1 (no commitment) to 10 (extremely high level of commitment).

Prepare for End of Treatment

Once treatment is halfway completed, the counselor prepares the client for termination:

C: *We have three sessions remaining. How do you feel this has been going? What would you like to accomplish in our remaining time together?*

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor explains that the client will report back on his or her efforts to complete the between-session exercises at the next session.

Overview of Session 7: Skill Topic 5, Problemsolving

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (form is at the end of this section):

- *Problemsolving* (form 7A)
- Large paper, posterboard, or dry-erase board to diagram problemsolving steps

Goals for This Session:

- To introduce a strategy for solving problems
- To apply the problemsolving approach to marijuana use and related problems
- To prepare for termination of treatment

Session Outline:

1. Discuss the importance of solving problems
   - Explain that problem situations result in use when people think they have no effective coping responses to handle them
2. Describe problemsolving skills
   - Recognize the problem
   - Identify or elaborate the problem
   - Consider various approaches
   - Select the most promising approach
   - Evaluate effectiveness
3. Practice problemsolving skills
   - Work through the process, identifying and applying problemsolving skills
   - Role play solutions and evaluate effectiveness
4. Assign between-session exercise
5. Review and conclude session

Session 7 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor explains the steps involved in problemsolving. Providing formal training in solving problems may accelerate the development of higher order coping strategies that go beyond situation-specific skills. This training helps clients act as their own counselors when they are no longer engaged in a formal treatment situation. The problemsolving approach used in BMDC is adapted from D'Zurilla and Goldfried (1971; see also CSAT 1998).

Discuss the Importance of Solving Problems

The counselor explains the rationale for learning an approach to solving difficult problems:

Counselor (C): *Situations become problems when people think they have no effective coping responses to handle them. Individuals can be flooded by emotions when faced with a problem and may be unable to manage the problem constructively. People who use marijuana and other drugs may encounter the following types of problems:*

- *Situations where drug use had occurred*
- *Situations that arise after drug use has been stopped (e.g., social pressure to use, cravings, slips)*
- *Difficulties developing new activities that help maintain abstinence (e.g., new recreational habits).*

The counselor describes steps to solve problems and situations where the approach is helpful:

C: *Effective problemsolving requires recognizing when you're confronted with a problem and resisting the temptation to respond impulsively or to do nothing. Coming up with an effective solution requires that you assess the situation to decide the best action.*

Sometimes the problem involves wanting to use drugs, such as at a party. At other times, the problem may be the urge to find a quick and easy solution. The pressure may get to you and trigger using. Effective problemsolving strategies must be part of your abstinence program because the occurrence of problems can set the stage for a relapse.

Describe Problemsolving Skills

The problemsolving approach involves the following phases:

1. Recognize the problem
2. Identify or elaborate the problem
3. Consider various approaches
4. Select the most promising approach
5. Evaluate effectiveness.

The counselor describes the steps involved in solving problems and provides examples:

C: ***Recognize the problem*** *(*adapted from Intagliata 1979*). What clues indicate a problem? You get clues from your body (e.g., indigestion, craving), your thoughts and feelings (e.g., feelings of anxiety, depression, loneliness, fear), your behavior (e.g., have you been meeting your own behavioral standards?), the way you respond to others (e.g., anger, lack of interest, withdrawal), and the way others respond to you (e.g., they appear to avoid you, criticize you).*

Identify or elaborate the problem. *What is the problem? Having recognized that something is wrong, you identify the problem precisely by gathering as much information*

as you can. Break the problem down into specific parts; you may find it easier to manage several parts than to confront the entire problem all at once.

Consider various approaches *(*adapted from Bedell et al. 1980*). What are the options? Develop several solutions; the first one that comes to mind may not be the best. Use the following methods to find a good solution:*

- ***Brainstorm.*** *Generate ideas without stopping to evaluate how good or bad they are. Write down all the ideas you come up with (even impractical ones) so that you can review them as you decide which to try. More is better. Don't judge these ideas.*
- ***Consider both behavioral and cognitive coping strategies*** *(*Sanchez-Craig 1983*). When the problem involves conflict with others, speak up assertively (behavioral coping) to improve the situation. When the problem involves negative emotional reactions to uncontrollable events, change the way you think about the situation (cognitive coping). Some problems require both behavioral and cognitive coping.*

Select the most promising approach. *What will happen if . . . ? Identify probable outcomes for each approach; include positive and negative outcomes and long- and short-term consequences. Consider the resources you'll need for each solution. Rank the possibilities by their consequences and desirability. The solution with the most positive and fewest negative consequences is the one to try first.*

Evaluate effectiveness. *How did it work? Evaluate the strengths and weaknesses of your plan. What difficulties did you encounter? Are you getting the expected results? Can you do something to make the approach more effective? Use the same clues as before (e.g., from your body, thoughts, feelings, other people) to decide whether your solution is effective. If you give the plan a fair chance and it doesn't solve the problem, move to your second choice and follow the same procedure.*

Practice Problemsolving Skills

The counselor encourages the client to work through the problem-recognition stage: identifying problems, describing each, and writing solutions on paper. The counselor asks the client to weigh alternatives, select the most promising one, and describe both advantages and disadvantages for every alternative. Finally, the client prioritizes the alternatives. The counselor and client role play and evaluate the effectiveness of the most promising solutions:

C: *Your upcoming business trip will put you in a tough situation because you'll be around old friends with whom you got high. What is the problem as you see it?*

Miguel (M): *I remember the good old times when we would get together and have a great time.*

C: *Like nostalgia.*

M: *Yeah; I see these colleagues two or three times a year, and we always smoked together.*

C: *That's a good description of the situation, but how do you see the problem?*

M: *I'm worried that being out of town, away from my family, I'll give in and get high. I know that if I do, I'll be upset later.*

C: *You want to see these people, but you're concerned about a possible lapse because you'll want to smoke with them. Have you thought of solutions and how effective they'll be?*

Assign Between-Session Exercise

The counselor presents *Problemsolving* (form 7A), reviews it, and asks the client to complete the practice exercise for the next session.

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor explains that the client will report back on his or her efforts to complete the between-session exercise at the next session. The counselor might remind the client that treatment will be ending soon and solicit the client's feelings about termination and input on the best way to spend the remaining sessions.

Overview of Session 8: Skill Topic 6, Marijuana Refusal Skills

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Material (form is at the end of this section):

- *Marijuana Refusal Skills* (form 8A)

Goal for This Session:

- To learn about and practice assertive responses to offers of marijuana use

Session Outline:

1. Discuss the effects of social relationships
   - Explain that marijuana use limits one's social group to those who use; explain that this makes it harder to stay abstinent because it increases
     - — Direct and indirect pressure to use
     - — Cravings associated with people, places, activities, etc.
     - — Positive expectancies about the effects of use
     - — Access to and availability of marijuana
2. Discuss social pressures, risky situations, and assertiveness
   - Explain that avoidance of risky social situations is the safest behavior
   - Explain that refusing marijuana requires assertiveness skills
   - Provide guidance for marijuana refusal: nonverbal behavior, oral responses, requesting behavior change, changing the subject, avoiding excuses
3. Rehearse behaviors
   - Role play refusal skills with client
   - Process the role play
   - Reverse roles with client and model a refusal skill
4. Assign between-session exercise
5. Review and conclude session

Session 8 Protocol

The counselor welcomes the client and provides an overview of the session. In this session, the counselor explains that marijuana-use offers and pressures are common high-risk situations for individuals who have stopped using marijuana. The counselor and client role play marijuana refusal skills.

Discuss the Effects of Social Relationships

The counselor explains that, as a person's marijuana use increases, his or her social relationships narrow. The individual spends less time with friends who do not use, and his or her peer group becomes mostly those who support and reinforce use. Being with such individuals increases the risk of relapse through increased

- Direct and indirect pressure to use
- Cravings associated with people, places, activities, and emotional states related to using
- Positive expectancies about the effects of using
- Access to and availability of substances.

Counselor (C): *People experience two forms of social or peer pressure: direct and indirect. Direct social pressure begins with an offer of marijuana. Indirect social pressure comes with a return to the same settings, people, and activities that generate feelings associated with using.*

Because social pressure increases risk greatly, avoiding risky social situations is the safest behavior. However, avoiding social pressure is not always possible or practical.

Being able to refuse marijuana requires more than a decision to stop using. It requires assertiveness to act on that decision. Practicing refusing marijuana will help you respond quickly and effectively when real situations arise.

Discuss Social Pressures, Risky Situations, and Assertiveness

The counselor describes offers that may occur and with the client devises strategies for avoiding such situations. It is best to avoid situations where people are using marijuana or to leave as soon as possible. But if the client is unable to avoid certain people and situations, the next level of response is to refuse to participate in smoking marijuana. The counselor tells the client that the more quickly the person says no, the less likely he or she is to relapse. Being unsure and hesitant allows the client to begin rationalizing (e.g., *One hit wouldn't be so bad*). The goal is to be ready and to say no immediately and convincingly.

An assertive response to an invitation to use depends on who offers the marijuana and how the offer is made. Sometimes a simple *No, thank you* is sufficient; at other times, additional strategies are necessary. Telling the person about prior using problems is useful in eliciting helpful support; at other times, it is unnecessary or even detrimental to share that information.

The counselor provides guidance for marijuana refusal:

C: ***Nonverbal behaviors.*** *Make direct eye contact with the person to increase the effectiveness of your message. Don't feel guilty. You won't hurt anyone by not using. In many situations, people won't even know that you're not using. You have a right not to use. Stand up for your rights!*

Oral responses. *Speak in a clear, firm, and unhesitating voice. Otherwise you invite questions about whether you mean what you say. "No" should be the first word out of*

your mouth. Suggest something else to do (e.g., go for a walk to talk, go to the movies instead of using on a Saturday night). Suggest having something to eat or a cup of coffee.

Requesting a behavior change. *If a person repeatedly pressures you, ask him or her not to offer you marijuana any more. For example, if the person says, "Oh, come on, let's get high the way we used to," an effective response might be, "If you want to be my friend, then don't offer me marijuana."*

Changing the subject. *After saying "No," change the subject to avoid getting drawn into a debate about using. You could say, "No, thanks, I don't get high. You know, I'm glad I came to this party. I haven't seen a lot of these people in a while, including you. In fact, I was wondering what you've been up to lately."*

Avoiding excuses. *Avoid excuses ("I'm on medication for a cold right now") and avoid vague responses ("Not tonight"). They imply that at some date you'll accept an offer.*

Rehearse Behaviors

The counselor acknowledges that the client may feel uncomfortable at first about role playing and that this is a normal reaction. The counselor assures the client that, with practice, the client will get into a scene realistically and focus on his or her role. Resistance can take subtle forms such as focusing on other issues or asking many questions.

The counselor develops scenes for role plays that are relevant to the client. Meaningful scenarios increase engagement in the role play and the likelihood that the client achieves a sense of mastery over the situation. The following strategies are useful in generating scenes:

- **Recalling events.** The counselor asks the client to recall a recent event in which he or she could have used the skill being taught.
- **Anticipating future triggers.** The counselor asks the client to anticipate a difficult situation that may arise in which the skill can be used.
- **Making suggestions.** The counselor suggests an appropriate situation based on his or her knowledge of the client's circumstances.

The counselor and the client anticipate a future trigger in this role play.

C: *It might help to practice what you can say to your colleagues when they are socializing after your business meeting.*

Miguel (M): *Sure, I'm willing to try it.*

C: *I'll play one of your colleagues, and you practice some responses. Hey, Miguel! Good to see you. Why don't you come to my room and we'll burn a few?*

M: *It's good to see you too! I hope you won't be offended, but since I saw you last, I've stopped smoking. I'd love to spend some time with you though.*

C: *Aw come on! Just a few tokes for old times' sake?*

M: *How about we just sit and talk. I really don't want to smoke pot anymore.*

C: *Great job!*

After completing a role play, the counselor and client must process it effectively. Processing provides an opportunity for a client to receive praise and constructive criticism and includes the following:

- The counselor and client react to the role play, considering how they felt about the way the situation was handled and the effects of the interaction.
- The counselor's comments provide sincere reinforcing and constructive criticism. Positive and negative feedback focuses on specific aspects of the person's behavior and points out what was particularly effective or ineffective.
- The counselor tries a role reversal. The client plays the role of the target person. This strategy is useful if a client has difficulty using a skill or is pessimistic about the approach's effectiveness. By playing the other person, the client has an opportunity to experience the effects of the skill.

In another situation, the counselor and client switch roles. The counselor plays a person who is offered marijuana at a party. The client plays the person offering marijuana by saying, "Here, help us celebrate." The client ignores the counselor's refusal and says, "Oh, come on, getting high won't hurt you." The counselor, in the role of the person being pressured, demonstrates an effective and assertive way to handle the situation.

Some role plays require using more than one partner, such as a group of people sitting around a dining room table offering multiple prompts to use. The counselor encourages the client to visualize such scenarios even though the individual therapy setting does not provide multiple partners. The counselor attempts to rehearse a variety of scenes involving colleagues, parties, restaurants, old friends, and new acquaintances. The counselor elicits the client's suggestions about how the person offering marijuana will react to the client's refusal to use.

Assign Between-Session Exercise

The counselor reviews *Marijuana Refusal Skills* (form 8A) and asks the client to complete the form before the next session.

Review and Conclude Session

The counselor reviews the content of the session, asks the client for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The counselor explains that the client will report back on his or her efforts to complete the between-session exercise at the next session. The counselor might remind the client that treatment will be ending soon and solicit the client's feelings about termination and input on the best way to spend the remaining session.

Elective Skill Topics

The four sessions that follow are elective. The counselor and client determine which topic would be the most helpful and use that as session 9. Following are the elective skill topics:

- Planning for emergencies and coping with a lapse
- Recognizing seemingly irrelevant decisions
- Managing negative moods and depression
- Demonstrating assertiveness.

At the end of session 9, the counselor and client discuss termination issues. The following topics are suggested:

- **The course of treatment.** What were the pros and cons? Did the treatment meet the client's expectations?
- **Thoughts, feelings, and concerns about terminating from treatment.** The counselor encourages the client to process feelings about ending, saying goodbye, and moving on.
- **Future plans.** What does the client anticipate in the upcoming weeks and months regarding marijuana use, possible high-risk situations, use of coping strategies, involvement in further treatment for marijuana use, or other concerns?
- **Continuing care.** The counselor offers the client a list of mutual-help resources available in the community.

Note: The counselor stresses that if a client lapses or feels the need for more treatment, he or she can return to the facility.

Overview of Session 9: Elective Skill Topic 1, Planning for Emergencies and Coping With a Lapse

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (all forms except forms 1A, 1B, and 1C, which are in section V, are at the end of this section):

- *Personal Emergency Plan: High-Risk Situation* (form 9A)
- *Personal Emergency Plan: Lapse* (form 9B)
- *Learning New Coping Strategies* (form 1A)
- *A Guide to Quitting Marijuana* (form 1B)
- The client's *Quit Agreement* (form 1C)

Goals for This Session:

- To increase preparedness for unexpected triggers and situations likely to promote relapse
- To learn techniques to manage the aftermath of a lapse or relapse of marijuana use
- To review the client's treatment

Session Outline:

1. Explain the effects of major life changes
2. Present *Personal Emergency Plan: High-Risk Situation* (form 9A)
3. Present *Personal Emergency Plan: Lapse* (form 9B)
4. Review Previous Skill Topics
   - Review strategies from previous skill topics that the client found helpful
   - Review *Learning New Coping Strategies* (form 1A), *A Guide to Quitting Marijuana* (form 1B), and the client's *Quit Agreement* (form 1C)
5. Terminate treatment

Session 9 Protocol: Elective Skill Topic 1

The counselor welcomes the client and provides an overview of the session. In this session, the counselor helps the client develop an emergency plan to follow in high-risk situations.

Explain the Effects of Major Life Changes

The counselor explains that life changes, both negative (e.g., health problems, unemployment, financial losses) and positive (e.g., a new job, graduating from school, moving to a new home) can threaten a client's efforts to remain abstinent. In these situations, the client needs an

emergency plan to cope with stressors. The counselor asks the client to consider possible high-risk situations and ways to address them.

Present Personal Emergency Plan: High-Risk Situation

The counselor gives the client *Personal Emergency Plan: High-Risk Situation* (form 9A), and together they review the form. The counselor and client fill out the form with the high-risk situations just identified in mind. The client might want to plan alternative enjoyable activities for high-risk times; the counselor can help the client with these plans. The counselor encourages the client to review compelling reasons for continued abstinence, as noted on the PFR (form AS8; see assessment session) or *Future-Self Letter* (form 4B).

Present Personal Emergency Plan: Lapse

The counselor explains that lapses are not uncommon and asks what might help the client leave a setting where a lapse occurred and whom he or she can call for immediate support.

The counselor presents *Personal Emergency Plan: Lapse* (form 9B) and asks the client to think of strategies to cope with a lapse. The counselor helps the client specify how the strategies would be carried out, such as how to dispose of the marijuana (e.g., throw it away, flush it down the toilet), how to challenge negative thoughts (e.g., *I'll quit again after I finish this stash; My life is just too stressful; I was so irritable when I quit last time, I should continue using because I'm nicer to be around*). The client already should have removed paraphernalia from his or her home, but strategies may need to be reviewed.

Review Previous Skill Topics

The counselor and client discuss strategies from previous skill topics that the client found helpful (e.g., urge surfing, challenging negative thinking) and review *Learning New Coping Strategies* (form 1A), *A Guide to Quitting Marijuana* (form 1B), and the client's *Quit Agreement* (form 1C).

Terminate Treatment

If this is the final treatment session with this client, the counselor discusses termination issues (see pages 18 and 131).

Overview of Session 9: Elective Skill Topic 2, Recognizing Seemingly Irrelevant Decisions

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Material (form is at the end of this section):

- *Seemingly Irrelevant Decisions* (form 9C)

Goals for This Session:

- To increase awareness of the decisionmaking process
- To recognize how certain choices increase the likelihood of a return to marijuana use

Session Outline:

1. Provide information on effects of seemingly irrelevant decisions
   - Tell George's story
2. Help the client anticipate thoughts of himself or herself as a victim
3. Discuss valuing self-reflection
   - Explain that though people commonly act in an automatic way, it's important when learning new behaviors to be aware of and reflect on decisions and actions
   - Encourage the client to become aware of activities and choices
   - Encourage the client to think about every choice he or she makes
4. Discuss the role of consciousness in decisionmaking
5. Introduce topic exercises
   - Ask about the client's most recent use and trace back the decisionmaking chain
   - Ask about weekend plans and develop a plan to avoid risky situations
6. Terminate treatment

Session 9 Protocol: Elective Skill Topic 2

The counselor welcomes the client and provides an overview of the session. In this session, the counselor helps the client recognize and handle seemingly irrelevant decisions.

Provide Information on the Effects of Seemingly Irrelevant Decisions

The counselor helps the client understand that apparently irrelevant decisions can have major repercussions (see Marlatt and Gordon 1985):

Counselor (C): *Many ordinary choices seem to have nothing to do with using. Although they may not involve choosing directly whether to use, they move you closer to making that choice.*

Through a series of minor decisions, you come to a point where using becomes likely. These seemingly unimportant decisions that put you on a path to resuming marijuana use are called seemingly irrelevant decisions. [Refers to form 9C.]

The counselor tells a story about relapsing (adapted from Carroll 1998):

C: *George was driving home from work and decided to take the scenic route. He realized he had forgotten to call his wife to say he'd be late. While looking for a pay phone, he remembered that his old smoking buddy Ric lived nearby, so he decided to stop at Ric's to use the phone. It was a Friday evening, which he remembered was party night for Ric. George noticed several cars parked at Ric's house. He paused a moment to deliberate, deciding that he needed to call his wife and told himself that he would go in for a minute to use the phone. Ric answered the door clearly stoned and invited him to reconnect with old friends. George entered the smoke-filled house and recognized friends from his using days who passed him a blunt. Debating only a second, George took it and began to smoke. That was the first of many he had that night. Because George's marijuana use was linked with these friends, his choosing Ric's house to make his call led to his getting high that night.*

You can see that George made several decisions that led up to his final decision to smoke. At each point, George could have made a different decision that would have kept him from a dangerous situation. Did he have to call his wife? Did he have no alternative but Ric's house? Could he have said no to his friends? Each decision brought George closer to danger. Ultimately, George's decision to have that blunt led to his relapse to marijuana use.

Help the Client Anticipate Thoughts of Himself or Herself as a Victim

The counselor helps the client anticipate future thoughts:

C: *People often think of themselves as victims ("Things happened, I ended up in a risky situation, and I got high; I couldn't help it"). They don't recognize that their little decisions gradually bring them to their predicament. After the fact, it's easy to see how you set yourself up for relapse, but it's harder to see what can happen when you're making the decision. So many choices don't seem to involve using at the time. Each choice may take you a little bit closer to making a big choice. When marijuana isn't on your mind, it's hard to connect using to a minor decision that seems removed from using.*

Discuss Valuing Self-Reflection

The counselor reminds the client that acting without thinking it through is common. People develop automatic processes that allow important tasks to be completed, but in treatment the client is encouraged to be aware of activities and choices. During the early phases of learning something new and essential to one's survival or emotional health and well-being, such as stopping substance use, the client needs to be aware of his or her choices and decisions. This increases the likelihood that each choice moves the person toward his or her goals.

The counselor stimulates the client's ability to be aware of his or her thoughts and choices:

C: *Think about every choice you make, no matter how seemingly irrelevant it is to using marijuana. By thinking ahead about each option you have and where each choice may lead, you can anticipate dangers that may lie along certain paths.*

By paying more attention to the decisionmaking process, you'll have a greater chance to interrupt the chain of decisions that could lead to a relapse. It's easier to stop the process early, before you wind up in a high-risk situation, than later, when you're in a situation that's hard to handle because you're exposed to triggers.

When you pay attention to your decisionmaking process, you can recognize certain thoughts that can lead to risky decisions, such as the thought George had to call home. Thoughts like you have to go to a party, have to see a certain person you used marijuana with, or have to drive by a particular place often occur at the beginning of a seemingly irrelevant decision and should be treated as a warning or red flag. Other red flag thoughts often start "It doesn't matter whether I…" or "I can handle…".

Discuss the Role of Consciousness in Decisionmaking

The counselor encourages the client to plan coping approaches:

C: *When faced with a decision, you should choose a low-risk option, one that will help you avoid a risky situation. However, if you select a high-risk option, you must plan to protect yourself. By becoming aware of seemingly irrelevant decisions, you can take action to avoid high-risk situations. It is easier to avoid a high-risk situation than it is to resist temptation once you're in it.*

Introduce Topic Exercises

The counselor introduces several exercises pertinent to this session:

C: *Think about your most recent marijuana use. Follow the decisionmaking chain. What was the starting point (e.g., exposure to a trigger, certain thoughts)? Can you recognize the points where you chose to make a risky decision?*

Have you made plans for this weekend? If no, why not? Is this a seemingly irrelevant decision? Sometimes not making any plans means planning to use. What plans can you make for this weekend to avoid a risky situation?

Here are other examples of situations involving seemingly irrelevant decisions that can be setups for a relapse. Which ones apply to you? What is a low-risk option for each?

- *Whether to keep marijuana in the house*
- *Whether to offer a ride home to a friend you used to smoke with*
- *Whether to tell a friend you've quit using.*

In the following dialog the counselor inquires about potential seemingly irrelevant decisions:

C: *You've gone several weeks without smoking. That's quite an accomplishment.*

Doug (D): *Yeah, I never thought I could go that long.*

C: *What caught your attention during our talk about seemingly irrelevant decisions?*

D: *I put a secret stash in the garage several months ago. Sometimes I forget it's there, but I guess I want a way out if things get too tough.*

C: *You seem concerned about it.*

D: *Yeah, that idea that not making plans may mean planning to smoke hit me right between the eyes. As long as I keep pot around, I guess I'm planning to smoke it sooner or later.*

C: *What are you thinking about now that you know that?*

Terminate Treatment

If this is the final treatment session with this client, the counselor discusses termination issues (see pages 18 and 131).

Overview of Session 9: Elective Skill Topic 3, Managing Negative Moods and Depression

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (all forms are at the end of this section):

- *Thinking Errors That Dampen One's Mood* (form 9D)
- *Managing Negative Moods and Depression* (form 9E)
- *Pleasant Activities* (form 4C)

Goals for This Session:

- To become more aware of how moods affect marijuana use
- To learn strategies to recognize, process, and cope with these emotions

Session Outline:

1. Address the possibility of negative moods
2. Discuss the importance of emotional triggers
   - Review *Thinking Errors That Dampen One's Mood* (form 9D)
   - Ask the client to identify which automatic negative thoughts he or she may engage in before or during depressed, anxious, or irritable moods
   - Discuss with the client guidelines for evaluating these thoughts
   - Give client *Managing Negative Moods and Depression* (form 9E)
   - Engage the client in problemsolving to address problems contributing to his or her negative moods
   - Give the client *Pleasant Activities* (form 4C) and help generate a list of appealing activities
   - Discuss balancing "have to" activities with "want to" activities
   - With a depressed client, discuss strategies that may help the client start a necessary or desirable activity
3. Link negative moods and marijuana use
   - Explore the relationship between the client's marijuana smoking and his or her experience of negative moods
   - Review *Thinking Errors That Dampen One's Mood* (form 9D)
   - Explain "cognitive distortions"
   - Explore automatic thought patterns that appear to lead to negative mood states
   - Explore methods of changing the client's automatic thoughts
4. Terminate treatment

Session 9 Protocol: Elective Skill Topic 3

The counselor welcomes the client and provides an overview of the session. In this session, the counselor assesses the client's level of depression and determines whether additional services are required. The client learns to recognize and cope with negative affective states.

Address the Possibility of Negative Moods

The counselor explains that negative moods (e.g., anxiety, irritability, depression) are common among people overcoming marijuana dependence:

Counselor (C): *Moods may relate to the effects of stopping marijuana use or the losses in one's life (e.g., family, job, finances) resulting from marijuana use. Difficulties with negative mood states (e.g., depression) may have started before marijuana use and may serve as a trigger for continued use. Abstinence from marijuana usually leads to improved mood (especially as clients start to cope effectively with other problems), but some individuals experience depression or other moods even after being abstinent for several weeks.*

Because negative moods often pose a risk for relapse, the client should address them directly during treatment. The counselor focuses on negative moods through problemsolving and increasing pleasant activities. If after session 3 the counselor suspects that the client can benefit from additional counseling or psychotropic medications, the counselor explores these possibilities with the client, particularly a client who is severely depressed, has an anxiety disorder, or has a personal or family history of mental disorders or aggression.

The counselor discusses the following strategies to help clients with mild to moderate levels of depression identify negative feelings:

- Increase awareness of negative moods and overly negative thinking
- Challenge negative thoughts
- Solve problems
- Change the client's activity level
- Decrease negative activities.

The counselor asks the client whether he or she experiences mood swings, low energy level, changes in appetite and sleep, and suicidality. If indicated (e.g., in the case of suicidality) the client should be referred for assessment by a mental health professional. He or she encourages the client to be aware of possible distorted perceptions that may precede or coincide with negative moods. The counselor encourages the client to pay attention to the contexts associated with mood changes and to watch for times when confidence level changes.

Discuss the Importance of Emotional Triggers

The counselor and client review *Thinking Errors That Dampen One's Mood* (form 9D). The counselor explains that a connection exists among how people think, feel, and behave and that the client can experience fewer negative moods if he or she thinks in realistic, balanced ways

rather than in overly negative, self-defeating ways. The client identifies which automatic negative thoughts he or she engages in. If the client has difficulty identifying these thoughts, the counselor tells the client to slow down the action (as if watching a movie in slow motion) or look at what the situation means. Sometimes writing down the most distressing thoughts helps a client remember his or her thoughts.

Once the client identifies his or her automatic negative thoughts, the counselor gives the client *Managing Negative Moods and Depression* (form 9E). The counselor tells the client to fill out the form thinking about distressing situations to avoid and recognizing that an event often can be interpreted in more than one way (Emery 1981).

The counselor engages the client in problemsolving to address problems contributing to negative moods. The problemsolving steps are reviewed briefly, emphasizing brainstorming and selecting the most promising approach.

The counselor encourages the client to consider increasing involvement in positive activities and reducing involvement in negative ones. Increasing positive activities improves mood by counteracting fatigue and improving motivation. *Pleasant Activities* (form 4C) (adapted from MacPhillamy and Lewinsohn 1982) or the calendar of events section in the local newspaper may help the client generate a list of enjoyable activities.

The counselor tells the client to consider activities that vary in price and that can be enjoyed when a person is abstinent and to balance pleasant activities (e.g., a walk in a park, attending the theater) with required activities (e.g., working, cleaning, studying). Engaging in a pleasant activity for 30 minutes two or three times a week (e.g., exercising, reading a favorite author) can fit easily into the client's schedule.

A depressed client may need to schedule fewer activities and record them on a calendar. The client may need to be rewarded in some way (unrelated to using substances) for completing these activities (e.g., spouse agrees to prepare dinner).

Decide which activities the client must do and which can be delegated to others. If the activity cannot be delegated, the client explores ways to change the context associated with the activity (e.g., call a friend only after an hour of studying, combine studying with music that is not distracting). If the client reports difficulty starting a necessary activity, he or she might try to do the activity for only a short time, perhaps 15 minutes. Some less desirable activities can be eliminated by problemsolving, time management (e.g., prioritizing tasks, setting time limits to complete tasks), and setting appropriate limits on others' requests.

Link Negative Moods and Marijuana Use

The counselor explores the relationship between marijuana smoking and the experience of negative moods and the role of automatic thoughts:

Shirley (S): *I miss smoking pot when I'm overwhelmed by bad feelings. I felt better after getting high.*

C: *Smoking helped you cope with your negative mood.*

S: *Yeah, but I would get depressed again when I came down from the high.*

C: *What works for you in the short term causes other problems later.*

S: *Yeah.*

C: *Today we've reviewed ways to cope with negative thoughts. You said getting up and moving around helps. Researchers have found that often the negative feelings don't just happen. That is, they don't come from nowhere. In fact, negative feelings may be related to the way we think about things or the way we interpret situations.* Thinking Errors That Dampen One's Mood *lists types of thoughts that increase the chances of feeling depressed. We call them cognitive distortions because they don't reflect what's going on but are based on an interpretation of events. Let's look at automatic thought patterns you have that lead to depression.*

Terminate Treatment

If this is the final treatment session with this client, the counselor discusses termination issues (see pages 18 and 131).

Overview of Session 9: Elective Skill Topic 4, Demonstrating Assertiveness

Total Time: 1 hour

Delivery Method: CBT-focused individual therapy

Materials (all forms are at the end of this section):

- *Assertiveness* (form 9F)
- *Assertiveness Practice Exercises* (form 9G)
- Chalkboard or newsprint

Goal for This Session:

- To improve the ability to express feelings and needs to others in an effective way

Session Outline:

1. Elicit client's definition of assertiveness
2. Define aggressive, passive, passive–aggressive, and assertive
3. Explain benefits of assertiveness
   - Increases chances that a person will meet goals
   - Increases likelihood that a person will feel good about a situation
4. Introduce skill guidelines
   - Review *Assertiveness* (form 9F)
   - Discuss handling situations with negative consequences
5. Model assertiveness
   - Role play passive, aggressive, passive–aggressive, and assertive responses
   - Ask the client to identify each behavior and its influence on preventing a slip
6. Practice assertive responses to past difficult situations
   - Review *Assertiveness Practice Exercises* (form 9G)
7. Terminate treatment

Session 9 Protocol: Elective Skill Topic 4

The counselor welcomes the client and provides an overview of the session. In this session, the counselor explains and models assertive behavior. The counselor may be surprised about the misconceptions a client has about assertiveness.

Elicit the Client's Definition of Assertiveness

The counselor asks the client to define *assertiveness*, writing this definition on a chalkboard or newsprint. The counselor compares the client's definition with the one presented in this skill topic, pointing out differences. The client may give an appropriate definition, but during role plays, it may become apparent that his or her behavior is inconsistent with that definition:

Counselor (C): *Today we're going to talk about assertiveness. When you hear that word, what do you think of?*

Doug (D): *People who are pushy, trying to get their way all the time.*

C: *We'll be looking at four styles of interacting: aggressive, passive, passive–aggressive, and assertive.* [Writes them on the chalkboard.]

D: *I guess I was thinking of the aggressive style, not assertive.*

C: *Let's define each style and see whether you identify with them. We can look at ways to communicate thoughts and feelings without offending other people or compromising your needs.*

Define Aggressive, Passive, Passive–Aggressive, and Assertive

The counselor helps the client understand the concept:

C: *Assertiveness means recognizing your right to decide what to do in a situation rather than give in to others. It recognizes and respects the rights of the people. Rights refer to*

- *The right to inform others of your opinion*
- *The right to inform others of your feelings in a way that is not hurtful*
- *The right to ask others to change their behavior that affects you*
- *The right to accept or reject what others say to you or request from you.*

We can express our needs to others in several ways: passive, aggressive, passive–aggressive, and assertive.

***Passive** people give up their rights if a conflict exists between what they want and what someone else wants. They usually fail to let others know what they're thinking or feeling. They bottle up their feelings, even when the situation doesn't require it, and often feel anxious or angry. Sometimes they feel depressed by their ineffectiveness or hurt when others have not drawn them out or figured out what they wanted. People do not know what the passive person wants, and passive people seldom get their needs met.*

***Aggressive** people protect their rights by running over others' rights. They may satisfy their short-term needs, but the long-term effects are negative. Because they disregard others to achieve their goals, they earn the ill will of others, who may seek to get even.*

***Passive–aggressive** people are indirect. They hint at what they want, make sarcastic comments, or mumble, without stating what is on their minds. They may act out by slamming doors, giving someone the silent treatment, or being late. They may get what they want without interacting directly. Frequently people around them become confused or angry, so the passive–aggressive person ends up feeling frustrated or victimized.*

***Assertive** people decide what they want, plan an appropriate way to involve others, and act on the plan. The most effective plan is to state one's feelings or opinions and request the changes one would like from others without making threats, demands, or negative statements. Usually assertive people decide in certain circumstances that a passive response is safest (e.g., with an insensitive boss) or that an aggressive response is necessary (e.g., in confronting a pusher who won't back off). Assertive people adapt their behavior so that it fits the situation; they don't respond in the same manner to all situations. Assertive people feel satisfied with their actions and are well regarded.*

Explain Benefits of Assertiveness

The counselor explains the benefits of assertiveness:

C: *Assertiveness is the most effective way to let others know what's going on or what effect their behavior has. By expressing themselves, assertive people resolve uncomfortable feelings that otherwise build up. Because being assertive often results in correcting a source of stress and tension, it can lead to feeling more in control of life. Assertive people do not feel like victims of circumstances. However, their goals can't be met in all situations; it isn't possible to control how another person will respond. Nevertheless, behaving assertively has two benefits: it increases the chances that goals will be met, and it makes people feel better about their role in the situation.*

Introduce Skill Guidelines

The counselor explains that the guidelines in *Assertiveness* (form 9F) can help the client become assertive:

C: *Take a moment to think before you speak. What did the other person do or say? Try not to assume the other person's intentions. Don't assume that he or she knows your mind.*

Plan the most effective way to make statements. Be specific and direct. Address the problem without bringing in other issues. Be positive. Don't put others down; blaming others makes them defensive and less likely to hear your message.

Pay attention to your body language: eye contact, posture, gestures, facial expression, and tone of voice. Make sure your words and your expression communicate the same message. To get your point across, speak firmly and be aware of your appearance.

Be willing to compromise. Let others know that you're willing to work things out. No one has to leave the situation feeling as if he or she has lost everything. Try to find a way for everyone to win. Give others your full attention when they reply, try to understand their views, and seek clarification. If you disagree, have a discussion. Don't dominate or submit to others. Strive for equality in the relationship.

If you feel you're not being heard, restate your assertion. Persistence and consistency are necessary parts of assertiveness. Changing the way you respond requires effort. The first step is to become aware of habitual responses and make an effort to change.

The most difficult situations in which to respond assertively are those that may end with negative consequences. Examine the thoughts that prevent you from acting assertively ("My boss will fire me if I can't work overtime because I have my counseling session"). This examination uses many skills we discussed under managing thoughts about marijuana:

- ***Determine the thought or fear.*** *What am I afraid will happen? What's the worst that could happen?*
- ***Assess the probabilities.*** *How likely is the negative consequence?*
- ***Evaluate the catastrophe.*** *What would happen if the worst occurred? Would it really be so terrible?*
- ***Identify the rules.*** *What assumptions and beliefs govern feelings?*

Model Assertiveness

The counselor and client role play a situation in which the counselor plays a person refusing to get high; the client plays the person offering the marijuana. The counselor models passive, aggressive, passive–aggressive, and assertive responses. After each response, the counselor asks the client to identify the behavior and determine the success of that approach.

Practice Assertive Responses to Past Difficult Situations

The counselor asks the client to list difficult situations he or she has experienced and to role play assertive responses. If the client has trouble thinking of situations, the counselor suggests some easy ones (e.g., returning an item bought in a store, dismissing a pesky salesperson) and some difficult ones (e.g., asking a friend to repay a loan several months old, confronting a supervisor who took credit for an idea of the client's). Following is an example of the counselor demonstrating how to assert feelings about being accused of smoking:

C: *You have said that you've been both passive and aggressive with your wife and son.*

D: *I get annoyed at first; then I get high and don't talk to them.*

C: *Would you like to role play some methods that we reviewed earlier in the skill topic?*

D: *Sure, since what I'm doing now isn't working!*

C: *Why don't you be your wife, and I'll try some responses we've talked about. Ready?*

D: *Yeah. Have you been smoking again? I can tell when you're sneaking around!*

C: *I haven't been smoking, and I don't appreciate the way you're confronting me.*

The counselor gives the client *Assertiveness Practice Exercises* (form 9G) and asks the client to practice the exercises at home.

Terminate Treatment

If this is the final treatment session with this client, the counselor discusses termination issues (see pages 18 and 131).

Forms for Sessions 3 Through 9

During the skill-building sessions, the counselor and client review or complete several forms. These forms are provided on the remaining pages of this section.

Problem Checklist

Category	Describe Problem	Severity (1–10)*	Goal
Housing/shelter			
Childcare			
Transportation			
Financial support			
Job training or employment			
Medical problems			
Legal problems			
Family problems			
Social or interpersonal problems			
Social support			
Emotional or psychological problems			
Education			
Other			

* 1 indicates no problem, 10 indicates a very severe problem that is likely to thwart your efforts to remain abstinent if not addressed.

Support Plan			
	Goal 1	**Goal 2**	**Goal 3**
What are my goals?			
Who is to be contacted? (Phone numbers and addresses)			
When will the contact be made?			
Who is responsible for contacting?			
What services will be requested?			
Outcome			

Others who can help with the plan: _____

_____

_____

_____

_____

Signature

Marijuana Use Self-Awareness Record

As a way to increase awareness about your patterns of use, we'll use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your marijuana use. It may be difficult initially, but once you get accustomed to paying more attention, you will become skilled at discovering the ways in which you typically use marijuana.

Trigger (What types of events tend to make you want to use? For example, an argument, disappointment, loss, or frustration; spending time with friends who use; having marijuana easily available to you; recalling positive memories of past use.)

1. _____

2. _____

Thoughts and Feelings (What were you thinking or how were you feeling in relation to the triggers you have identified? For example, thinking you were incompetent or stupid or that you could never achieve a particular goal; feeling angry, sad, frightened, or glad.)

1. _____

2. _____

Behavior (What did you actually do when you were thinking and feeling in these ways? For example, smoked marijuana, went out to dinner, isolated yourself from people.)

1. _____

2. _____

Positive Consequences (What good came out of your response to the situation? For example, I felt much better for a short period.)

1. _____

2. _____

Negative Consequences (What negative things happened as a result of your response? For example, I felt bad about myself for smoking; I couldn't complete the work I needed to finish.)

1. _____

2. _____

Future-Self Letter

Optional Creative Expression Exercise

Sometime during the next week, imagine that a year has passed and that you haven't used marijuana for a year. Making believe that it's next year, write a letter to yourself (the old you). Write about your life as it has become. Include the reasons why you stopped a year earlier, what your lifestyle is like in the new year, and the benefits you enjoy from not smoking. Mention in your letter any problems you faced during the past year in giving up marijuana use. Describe yourself without marijuana as clearly as you can. As you visualize yourself in the future without marijuana, it may help to think about friendships, self-esteem, health, employment, recreational activities, and general lifestyle satisfaction.

If you prefer, draw, sketch, or paint a picture of this image of yourself in the future, rather than depict it in writing. Choose a medium that will allow you to see another possibility for yourself.

This exercise is extremely useful. It helps you visualize your journey and your goal. Having a clear picture of where you're going, why, and how you're going to get there will be useful in the months ahead. At our next session, we'll talk about the future you foresee for yourself.

Pleasant Activities[1]

Optional Assignment

In stopping your marijuana use, you are giving up an activity that has taken up a great deal of your time. It is important that you identify other activities that bring you pleasure and integrate them into your everyday life. Your assignment is to do something nice for yourself every day, something you wouldn't necessarily spend the time, effort, or money to do for yourself otherwise. You may need to get your partner's, supporter's, or someone else's cooperation to do this, but don't hesitate to ask. It doesn't matter whether it's having dinner out, shopping for something you've been wanting, taking a hot bath, jogging—something that makes you feel as if you're treating yourself. You deserve it! If it involves spending a little more money than usual, remember that you'll be saving money by not smoking marijuana. You'll gradually find ways to treat yourself that are less expensive. Keep a record of these over the next week, and we'll discuss them next time.

	Plan for Increasing Pleasant Activities (List at least one target for each day)	Followup (What did you end up doing each day?)
Day 1		
Day 2		
Day 3		
Day 4		
Day 5		
Day 6		
Day 7		

[1]Source: MacPhillamy and Lewinsohn 1982.

Relaxation Training[2]

Optional Assignment

Deep Muscle Relaxation Practice Exercise

Arrange to spend some quiet time in a room where you will not be interrupted. Try to practice this relaxation technique at least three times during the next week. Proceed through the eight groups of muscles in the list below, *first tensing* each for 5 seconds and *then relaxing* each for 15 to 20 seconds.

Settle back as comfortably as you can, take a deep breath, and exhale very slowly. You may feel most comfortable if you close your eyes. Notice the sensations in your body; you will soon be able to control those sensations. Begin by focusing your attention on your hands and forearms.

- Squeeze both hands into fists, with arms straight. Then relax hands.
- Flex both arms at the elbows. Then relax arms.
- Shrug shoulders toward head. Tilt chin toward chest. Then relax shoulders and neck.
- Clench jaw, gritting your teeth together. Then relax jaw.
- Close your eyes tightly. Then relax eyes.
- Wrinkle up your forehead and brow. Then relax these muscles.
- Harden your stomach muscles, as if expecting someone to punch you there (continue to breathe slowly as you tense your stomach). Then relax stomach.
- Stretch out both legs, point your toes toward your head, and press your legs together. Then relax legs.

Self-Rating Task

Each day that you engage in this exercise, rate your relaxation level before *and* after, using the following guide: 0=highly tense; 100=fully relaxed.

Day	Time	Before	After

[2]Source: Monti et al. 1989.

Boredom Management

Optional Exercise

For many people who use marijuana, boredom is a trigger to smoke. Sometimes it is boredom associated with a tedious or uninteresting job. Perhaps it is a way to fill weekday evening hours after dinner but before bedtime. At other times, getting stoned is a way to spend a weekend when nothing else has been planned.

Boredom is a complex and interesting emotion. Many different feelings may be associated with it. For instance, boredom may be accompanied by anxiety, apathy, irritability, or lethargy. It's not a really strong emotion; it just kind of nags at you. It can sneak up because it's hard to identify. Discussing boredom and how to handle it can make you aware of its influence on your behavior and prepare you to cope with it.

A Boring Story

Jan was in her mid-30s when she began to think she needed to quit smoking pot. Sometimes she enjoyed it, but after 15 years of regular use Jan was unhappy with herself for smoking so much marijuana. She began every day with a hit and smoked every hour or two throughout the day.

Several times in the past few years she had tried to cut back to smoking just in the evenings and on weekends. A few times she kept to her limits, but inevitably she'd inch her way back up. When she thought about it, she recognized that she slipped back to getting stoned because she couldn't handle the boredom she felt when she was straight. Her job wasn't stimulating; she was a receptionist in a travel agency. When she tried to get through a day without smoking, the tedium of her job got to her.

Now as she thought about quitting pot completely, she couldn't imagine how she'd cope with being bored at work. On top of that, she was sure that the evenings and weekends would be miserable if she didn't get high. Being bored was torture for Jan. Boredom was an endless emptiness and an inner void, with unpleasant restlessness and anxiety. She wondered whether she had a chance of quitting marijuana.

Jan lived by herself and liked it that way. She had two close friends and worried about how these friendships would be affected if she stopped getting high. She feared that her being straight would alienate at least one friend. With fewer friends, boredom would be even worse!

1. *What does boredom feel like to you?*
2. *Is it always a miserable experience?*
3. *What makes boredom so uncomfortable?*
4. *How would you cope with being bored if you were Jan?*

Coping With Cravings and Urges[3]

- Urges are common in the recovery process. Do not regard them as signs of failure. Instead, use your urges to help you understand what triggers your cravings.
- Urges are like ocean waves. They get stronger only to a point; then they start to subside.
- You win every time you defeat an urge to use. Urges get stronger the next time if you give in and "feed" them. However, if you don't feed it, an urge eventually will weaken and die.

Practice Exercise

For the next week, make a daily record of urges to use drugs, the intensity of those urges, and the coping behaviors you used.

Fill out the *Daily Record of Urges To Use Marijuana* (form 5C):

- Date.
- Situation: Include anything about the situation and your thoughts or feelings that seemed to trigger the urge to use.
- Intensity of cravings: Rate your craving—1=none at all, 100=worst ever.
- Coping behaviors used: Note how you attempted to cope with the urge to use marijuana. If it helps, note the effectiveness of your coping technique.

[3]Source: Kadden et al. 1994.

Urge Surfing

Many people try to cope with their urges by gritting their teeth and toughing it out. Some urges, especially when you first return to your old using environment, are too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called *urge surfing.*

Urges are like ocean waves. They are small when they start, grow in size, and then break up and dissipate. You can imagine yourself as a surfer who will ride the wave, staying on top of it until it crests, breaks, and turns into less powerful, foamy surf. The basis of urge surfing is similar to that of many martial arts. In judo, one overpowers an opponent by first *going with* the force of the attack. By joining with the opponent's force, one can take control of it and redirect it to one's advantage. This type of technique of gaining control by first going with the opponent allows one to take control while expending a minimum of energy. Urge surfing is similar. You can join with an urge (rather than meet it with a strong opposing force) as a way of taking control of your urge to use. After you have read and become familiar with the instructions for urge surfing, you may find this a useful technique when you have a strong urge to use.

Urge surfing has three basic steps:

1. *Take an inventory of how you experience the craving. Do this by sitting in a comfortable chair with your feet flat on the floor and your hands in a comfortable position. Take a few deep breaths and focus inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge and tell yourself what you are experiencing. For example, "Let me see—my craving is in my mouth and nose and in my stomach."*
2. *Focus on one area where you are experiencing the urge. Notice the exact sensations in that area. For example, do you feel hot, cold, tingly, or numb? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations and describe them to yourself. Notice the changes that occur in the sensation. "Well, my mouth feels dry and parched. There is tension in my lips and tongue. I keep swallowing. As I exhale, I can imagine the smell and taste of marijuana."*
3. *Refocus on each part of your body that experiences the craving. Pay attention to and describe to yourself the changes that occur in the sensations. Notice how the urge comes and goes.*

Many people notice that after a few minutes of urge surfing the craving vanishes. The purpose of this exercise, however, is not to make the craving go away but to experience the craving in a new way. If you practice urge surfing, you will become familiar with your cravings and learn how to ride them out until they go away easily.

Daily Record of Urges To Use Marijuana[4]

Date	Situation (include your thoughts and feelings)	Intensity of Cravings (1–100)	Coping Behaviors Used

[4]Source: Kadden et al. 1994.

Managing Thoughts About Marijuana[5]

Here are several ways of managing thoughts about marijuana:

- Challenge your thought: Do you really need to use?
- Think of the benefits of not using (see Creating Your List below).
- Remember the unpleasant drug experiences and aftereffects (read list on card [see below]).
- Find distractions: Think of something unrelated to marijuana use.
- Think positively: Remind yourself of your successes so far.
- Leave or change the situation.
- Call your supporter or a friend and try to talk it out.
- Use self-talk.
- Use images of riding out the wave of craving until it passes.
- Use images or pictures of loved ones who would be disappointed if you used.
- Use the decision-delay technique: If nothing else is working, then look at your watch and put off a decision to use marijuana for 15 minutes or more (use images to tough it out until the urge passes).

Creating Your List

One way to cope with thoughts about using marijuana is to remind yourself of the benefits of not using, the unpleasant consequences of using, and the stumbling blocks or high-risk situations that may make it hard to keep your commitment to abstinence. Use this form to make a list of 5 to 10 reminders in each category, then transfer this list onto an index card. Carry the card with you, and read it whenever you start to have thoughts about using marijuana.

Positive benefits of not using: _____

_____

_____

_____

_____

_____

_____

_____

[5]Source: Monti et al. 1989.

Managing Thoughts About Marijuana (continued)

Unpleasant effects or negative consequences of using: _____

_____

_____

_____

_____

_____

Stumbling blocks or high-risk situations that make it difficult to keep commitment to abstinence:

_____

_____

_____

_____

_____

Overall level of personal commitment to remain abstinent:

1 2 3 4 5 6 7 8 9 10

None *Extremely High*

Overall confidence level in ability to remain abstinent:

1 2 3 4 5 6 7 8 9 10

None *Extremely High*

Problemsolving

Here is a brief list of the steps in the problemsolving process:

- *Is there a problem?* Recognize that a problem exists. We get clues from our bodies, our thoughts and feelings, our behaviors, our responses to other people, and the ways that other people respond to us.
- *What is the problem?* Identify the problem. Describe the problem as accurately as you can. Break it into manageable parts.
- *What can I do?* Consider various approaches to solving the problem. Brainstorm to think of as many solutions as you can. Consider acting to change the situation; consider changing the way you think about the situation.
- *What will happen if . . . ?* Select the most promising approach. Consider all the positive and negative aspects of each approach, and select the one most likely to solve the problem.
- *How did it work?* Assess the effectiveness of the selected approach. After you have given the approach a fair trial, determine whether it worked. If it did not, consider what you can do to improve the plan, or give it up and try one of the other approaches.

Practice Exercise

Select a problem that does not have an obvious solution. Describe it accurately. Brainstorm a list of possible solutions. Evaluate the possibilities, and number them in order of your preference.

Identify the problem: _____

_____

_____

_____

_____

List brainstorming solutions: _____

_____

_____

_____

_____

Marijuana Refusal Skills[6]

When others urge you to use, keep the following in mind:

- Say no.
- Speak in a clear, firm, and unhesitating voice.
- Make direct eye contact.
- Suggest an alternative: something else to do or something to eat or a cup of coffee.
- Ask the person to stop offering you marijuana and not to do so again.
- Change the subject.
- Avoid using vague answers or excuses.
- Don't feel guilty about refusing to use marijuana.
- Leave if the offerer persists.

Practice Exercise

Listed below are some people who might offer you marijuana in the future. Give some thought to how you will respond to them, and write your responses after each item.

Someone close to you who knows about your using problem: _____

_____

Colleague: _____

_____

Boss: _____

_____

New acquaintance: _____

_____

Someone at a party with others present: _____

_____

Relative at a family gathering: _____

_____

Boyfriend/girlfriend: _____

_____

[6]Source: Monti et al. 1989.

Personal Emergency Plan: High-Risk Situation[7]

If I encounter a high-risk situation,

- I will leave or change the situation or environment.
- I will put off the decision to use for 15 minutes. I will remember that most cravings are time limited and that I can wait it out and not use.
- I will challenge my thoughts about using. Do I really need marijuana? I will remind myself that my only true needs are for air, water, food, and shelter.
- I will think of something unrelated to using.
- I will remind myself of my successes to this point.
- I will call people on my list of emergency numbers:

	Names	Phone Numbers
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Remember: Riding out this crisis will strengthen my program.

[7]Source: Monti et al. 1989.

Personal Emergency Plan: Lapse

A lapse can represent a crisis in recovery. Returning to abstinence requires an all-out effort. Here are some things you can do.

If I do experience a lapse,

- I will get rid of the marijuana and get away from the setting where I lapsed.
- I will realize that a little marijuana or even 1 day of drug use does not have to result in a full-blown relapse. I will not give in to feelings of guilt or blame myself because I know these feelings will pass in time.
- I will call someone for help.

Remember: This lapse is only a temporary detour on the road to abstinence.

Write a detailed emergency plan for coping with high-risk lapse situations.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

Seemingly Irrelevant Decisions

When making any decision, whether large or small, do the following:

- Consider what options you have.
- Think about the possible outcomes of each option. What positive or negative consequences can you anticipate, and what are the risks of relapse?
- Choose an option that will minimize your relapse risk. If you decide to choose a risky option, plan how to protect yourself while in the high-risk situation.
- Watch for "red flag" thinking: thoughts like "I have to . . ." (do something, go somewhere, see someone) or "I can handle . . ." (a certain high-risk situation) or "It really doesn't matter whether . . ." (I'll just have a hit).

Practice Exercise

Think about a decision you made recently or are about to make. The decision could involve any aspect of your life, such as your job, recreational activities, friends, or family. Identify safe choices and choices that might increase your risk of relapsing.

Decision to be made: _____

_____

_____

_____

Safe alternatives: _____

_____

_____

_____

Risky alternatives: _____

_____

_____

_____

Thinking Errors That Dampen Oneís Mood[8]	
Type of Error	**Example**
Personalizing	Thinking all situations and events revolve around you. *Everyone was looking at me.*
Magnifying	Blowing negative events out of proportion. *This is the worst thing that could happen to me.*
Minimizing	Downplaying the positives. *I got the job, but probably no one else applied.*
Either/or thinking	Not taking into account the full continuum. *I'm either a loser or a winner.*
Taking events out of context	After a successful experience, focusing on one or two rough points. *I may have gotten the job, but I blew that one question in the interview.*
Jumping to conclusions	Making a premature conclusion without enough data. *I have a swollen gland. It must be cancer.*
Overgeneralizing	Making a sweeping judgment based on one event. *I failed this time; I fail at everything I ever try.*
Self-blame	Blaming oneself rather than specific behaviors that can be changed. *I'm no good.*
Mindreading	Believing that you know what everyone else is thinking. *Everyone there thought I was fat and ugly.*
Comparing	Comparing yourself unfavorably with someone else. *That supermodel has a better figure than I do.*
Catastrophizing	Focusing on the worst possible outcome or explanation. *He didn't call, and I know something terrible has happened to him.*

[8]Source: Emery 1981.

Managing Negative Moods and Depression[9]

Use the Three As to overcome your depression.

1. Be **aware** of the symptoms of depression.
   - Be aware of your moods and the situations that influence them.
   - Be aware of your automatic negative thoughts.
2. **Answer** or respond to these thoughts.
   - Ask questions and challenge the assumptions behind these thoughts.
   - Replace the negative thoughts with positive ones.
3. **Act** differently.
   - Increase your positive activities.
   - Decrease your involvement in unpleasant activities.
   - Reward yourself for the positive steps you're taking.

Practice Exercise

Use this worksheet to become aware of the issues involved in your depression and the steps you can take to change your moods.

1. What are the ways that I show my depression in my moods, attitudes, and actions? What are my symptoms? _____

   _____

   _____

2. What are the automatic negative thoughts that go along with my depression? What do I think about myself, my current situation, and my world in general? _____

   _____

   _____

3. What questions can I ask myself to challenge these automatic negative thoughts? _____

   _____

4. What steps am I going to take to act differently? What problemsolving strategies have I come up with to cope with my problems? What pleasant activities might I increase? What unpleasant activities might I avoid or minimize? _____

   _____

   _____

[9]Source: Kadden et al. 1994.

Assertiveness

Remember the following points in practicing assertiveness:

Take a moment to think before you speak.

Be specific and direct in what you say.

Pay attention to your body language (use direct eye contact; face the person you're addressing).

Be willing to compromise.

Restate your assertion if you feel that you're not being heard.

Assertiveness Practice Exercises[10]

These exercises will help you become aware of your style of handling various social situations. The four common response styles are passive, aggressive, passive–aggressive, and assertive.

Pick **two** different social situations. Write brief descriptions of them and of your responses to them. Then decide which of the four common response styles best describes each response.

Situation 1 (describe): _____

_____

Your response: _____

_____

Circle response style: *passive* *aggressive* *passive–aggressive* *assertive*

If your response was *not* assertive, think of an assertive response and write it down here: _____

_____

_____

Situation 2 (describe): _____

_____

Your response: _____

_____

Circle response style: *passive* *aggressive* *passive–aggressive* *assertive*

If your response was *not* assertive, think of an assertive response and write it down here: _____

_____

_____

[10]Source: Monti et al. 1989.

SECTION VII.
SUPPLEMENTAL READINGS

Supplemental Reading A: Who Needs Treatment? The Nature, Prevalence, and Consequences of Marijuana Dependence

Brief Marijuana Dependence Counseling (BMDC) is based on findings that show regular marijuana use can lead to a drug dependence syndrome characterized by impaired control over marijuana use, preoccupation with its use, tolerance of its effects, and recognizable withdrawal symptoms following abrupt discontinuation of its use. The syndrome typically develops over the course of years rather than months, with daily or near-daily marijuana smoking being the hallmark symptom.

The Nature of the Syndrome

A syndrome is a cluster of symptoms that signals the presence of an underlying disorder (see section IV of this manual for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition [DSM-IV]* [American Psychiatric Association 1994] criteria for marijuana dependence).

The marijuana dependence syndrome includes behavioral, psychological, and physiological symptoms that are typically reported by people who chronically smoke marijuana and who have difficulty controlling their use (Stephens and Roffman 1993). People who use marijuana daily develop tolerance for its subjective effects (e.g., feelings of being high) and cardiovascular effects (e.g., increased heart rate) (Compton et al. 1990; Wiesbeck et al. 1996). Some experience such difficulty in controlling their marijuana use that they continue to use despite adverse personal consequences of use (Stephens and Roffman 1993; Swift et al. 1998*a*, 1998*b*).

The relatively low intensity of physiological withdrawal symptoms resulting from heavy marijuana use may have contributed to marijuana's not being viewed as dependence producing. However, studies have documented that people who use marijuana heavily and chronically may develop both physiological and psychological dependence and that cessation from use may produce a withdrawal syndrome broadly characterized by restlessness, irritability, mild agitation, insomnia, decreased appetite, sleep disturbance, anxiety, stomach pain, nausea, runny nose, sweating, and cramping (Crowley et al. 1998; Haney et al. 1999*b*; Wiesbeck et al. 1996). These symptoms commonly abate within a few days to 2 weeks of abstinence from marijuana.

Considerable evidence of a biological basis for marijuana dependence has accumulated since the identification of a specific cannabinoid receptor in the brain (Pertwee 1999) and the discovery of anandamide, a compound that binds to and activates the same receptor sites in the brain as delta-9-tetrahydrocannabinol (THC), the active ingredient in marijuana (Devane et al. 1992). Subsequently, researchers discovered a cannabinoid antagonist, a compound that blocks anandamide action in the brain (Rinaldi-Carmona et al. 1994). With increased knowledge of the neurochemical basis of marijuana's reinforcing effects on brain systems, the biological basis of marijuana dependence is becoming better understood.

Prevalence

Marijuana is the most widely used illicit substance in the United States and is the third most widely used mood-altering substance after alcohol and tobacco. In 2003, more than 75 percent of illicit drug users (14.6 million people) smoked marijuana. For nearly 55 percent of illicit drug users, marijuana was the only substance they used (Substance Abuse and Mental Health Services Administration 2004). The proportion of young adults who use marijuana regularly has increased since the 1960s, and the age of initiation has declined (Hall et al. 1999). More risky patterns of smoking developed with the increased popularity of waterpipes or bongs, which permit the delivery of large doses of THC (Hall and Babor 2000). These conditions, combined with increased social tolerance of marijuana use, reduced penalties for possession, and the development of a substantial black market industry to distribute marijuana products, likely have increased the possibility that a substantial number of persons exposed to marijuana during their youth will continue to use the drug regularly into adulthood.

Epidemiological studies conducted in the last two decades have tracked trends in the prevalence of marijuana dependence. In the 1980s, the Epidemiological Catchment Area Study found that 4.4 percent of adults had been dependent on marijuana at some point in their lives (Anthony and Helzer 1991). About a decade later, the National Comorbidity Study estimated that 4.2 percent of the U.S. population met diagnostic criteria for marijuana dependence (Anthony et al. 1994). Whereas overall marijuana use was stable among the adult population in the 1990s, rates of dependence and abuse (as classified by the DSM-IV) increased significantly during the same period (Compton et al. 2004). These studies indicate that marijuana dependence is one of the most prevalent substance use disorders in the United States, exceeded only by nicotine and alcohol dependence.

The Natural History of Marijuana Dependence

For those who have used marijuana at least once, the relative probability of ever becoming dependent on the substance is estimated to be 9 percent. This level of risk is considerably lower than risk estimates of dependence for those who have used tobacco (32%), heroin (23%), cocaine (17%), or alcohol (15%) (Anthony et al. 1994). However, the risk of developing marijuana dependence may be higher among individuals who have smoked marijuana more frequently. Among those who have used marijuana five or more times, the risk of dependence is estimated to be 17 percent (Hall et al. 1999). For people who use daily or near daily, the risk may increase to 33 percent (Kandel and Davies 1992).

People using marijuana who are recruited into treatment outcome studies averaged more than 10 years of near-daily use and more than six serious attempts at quitting in the past (Stephens et al. 1994*b*, 2000). Their use had persisted in the face of multiple forms of social, psychological, and physical impairment, and most clients perceived themselves as unable to stop. In one study of 450 clients who used marijuana chronically (Stephens et al. 2002), clients had begun smoking in early adolescence, had begun regular smoking in their late teens, had begun to experience problems by age 27, and had felt they needed treatment by age 36.

Consequences of Marijuana Use

A number of potential adverse health and behavioral effects related to both acute intoxication and chronic ingestion have been identified in epidemiological studies and clinical research (Hall 1995;

Hall and Babor 2000). Several surveys of people using marijuana heavily who are not in treatment show that a majority report impairment of memory, concentration, motivation, self-esteem, interpersonal relationships, and health related to their marijuana use (Rainone et al. 1987; Roffman and Barnhart 1987). A similar profile of marijuana-related consequences is seen in samples of adults seeking treatment for marijuana dependence (Budney et al. 1998; Stephens et al. 1994*b*, 2000).

Exhibit VII-1 shows the frequency of self-reported problems in a group of 450 people who chronically used marijuana participating in the Marijuana Treatment Project (MTP) (Stephens et al. 2002). The table shows that clients who presented for treatment with primary marijuana dependence demonstrated a high prevalence of social, legal, medical, and psychological problems, which tend to be directly or indirectly connected with chronic marijuana use and acute marijuana intoxication (Hall et al. 1999).

Exhibit VII-1. Percentage of MTP Participants Who Endorsed Each Marijuana Problem Item (N=450)

Has marijuana caused you	% of Sample
To feel bad about your use	90.2
To have lower energy level	86.0
To procrastinate	86.0
Memory loss	76.4
To have lower productivity	75.1
Lowered self-esteem	74.2
To lack self-confidence	68.4
Withdrawal symptoms	61.1
Problems between you and your partner	58.0
Financial difficulties	48.9
Difficulty sleeping	46.0
Problems in your family	44.4
To neglect your family	38.7
Medical problems	33.6
Problems between you and your friends	26.4
To miss days at work or miss classes	19.8
To lose a job	8.2
Blackouts or flashbacks	7.6
Legal problems	7.1

Source: Stephens et al. 2002.

Driving performance following marijuana use has been studied in several contexts. Whereas marijuana impairs performance in laboratory and simulated driving settings, studies of on-road driving performance have found only modest impairments (e.g., Chesher 1995; Robbe 1994). Controlled epidemiological studies have not established an increased risk of motor vehicle crashes among those who use only marijuana (Smiley 1999). Marijuana's major public health significance for road safety may be to potentiate the adverse effects of alcohol on the performance of drivers who combine alcohol and marijuana intoxication (Hall and Babor 2000).

Reasonable evidence exists that marijuana use may precipitate schizophrenia in vulnerable individuals (Andreasson et al. 1987; Thornicroft 1990) and that continued use worsens the prognosis of persons with schizophrenia (Hall and Solowij 1998).

People whose use of marijuana is chronic and heavy report

- Subtle impairment in the ability to focus attention and filter out complex irrelevant auditory information (Solowij et al. 1991)
- Reduced verbal and logical reasoning abilities, diminished short- and long-term memory, and altered visual spatial ability (Lundqvist 1995)
- Mathematical and verbal expressive skill deficits (Block and Ghoneim 1993)
- Short-term deleterious impairment of executive functions (Pope et al. 1995); impairment in these abilities is likely to have an effect on occupational, academic, and interpersonal functioning.

Together, these cognitive impairments may make an individual feel isolated, misunderstood, and inadequate.

Because marijuana is most often smoked, the person who uses heavily may be at greater risk of respiratory diseases. Marijuana smoke is similar in composition to tobacco smoke and has been shown to increase chronic and acute bronchitis, cause functional alterations in the respiratory tracts, and produce morphologic changes in the airways that may precede malignant change (Hall and Babor 2000; Tashkin 1999). These adverse effects appear to occur with fewer marijuana cigarettes per day and at earlier ages in people who use marijuana than in tobacco smokers. In addition, concurrent marijuana use augments many of the effects of tobacco smoking. Approximately 50 percent of those who seek treatment for marijuana dependence also smoke tobacco (Budney et al. 1998; Stephens et al. 1993*a*), a rate that is significantly higher than for people of comparable age in the general population. The possibility that cancer may be induced by chronic marijuana smoking has been raised by case reports, which have described cancers of the aerodigestive system in young adults with a history of heavy marijuana use (e.g., Donald 1991; Taylor 1988). A recent epidemiological study found that chronic marijuana use may increase the risk of head and neck cancer with a strong dose-response pattern (Zhang et al. 1999).

Some studies have found maternal marijuana use to be related to preterm deliveries, low birth weights (Hatch and Bracken 1986; Zuckerman et al. 1989), and signs of neurological distress in newborns (Scher et al. 1988). Recent studies suggest subtle forms of cognitive impairment that do not become apparent until later in life in children born to mothers who use marijuana (e.g., Day et al. 1994; Richardson et al. 1995).

Conclusion

Research suggests that individuals can develop a dependence syndrome that is associated with recurrent psychological, social, and physical problems. The respiratory, psychological, and interpersonal problems often reported by people dependent on marijuana can lead to significant impairments in health and the quality of life.

Supplemental Reading B: How Effective Is Treatment for Marijuana Dependence? The Marijuana Treatment Project and Related Studies

Despite the need for marijuana dependence treatment in the United States, research on how to intervene effectively with this problem has been conducted only recently. This section describes the results of controlled trials conducted in the last decade to evaluate interventions for adults who are marijuana dependent. Special consideration is given to MTP, which is the largest study ever conducted of people who smoke marijuana.

Controlled Studies

The first controlled trial of marijuana dependence treatment (Stephens et al. 1994*b*) compared the effects of 10 sessions of cognitive behavioral therapy (CBT) with 10 sessions of group discussion. The participants were 212 people who had used marijuana daily or almost daily for an average of 10 years. Both counseling approaches were modestly effective in helping a significant portion of participants achieve either abstinence or improvement. Contrary to predictions, the CBT approach was no more effective than social support with adults who were marijuana dependent. Higher levels of pretreatment marijuana use predicted higher use levels following treatment. Lower socioeconomic status predicted more problems associated with marijuana use after treatment. Finally, individuals who before treatment indicated greater self-efficacy for avoiding marijuana use had more successful posttreatment outcomes (Stephens et al. 1993*b*).

In a related study (Stephens et al. 2000), a brief, 2-session individual treatment was compared with 14 sessions of CBT skills training. In this study a delayed treatment control group was included to determine the extent to which self-initiated change occurs in this population in the absence of formal treatment. This group was placed on a waiting list and asked to come back in 4 months. The sample consisted of 291 adults who smoked marijuana daily. The 14 CBT skills training sessions were delivered in a group setting over a 4-month period. This treatment emphasized the learning of coping strategies to deal with situations presenting high risk of relapse. It also provided additional time to build group cohesion and support. The second active treatment consisted of two motivational enhancement therapy (MET) counseling sessions delivered as individual therapy over a 1-month period.

An important element involved giving participants normative information so they could compare their marijuana use with that of the general population and that of other people seeking treatment for marijuana dependence. The counselor reviewed with each participant a written personal feedback report generated from questions asked during a comprehensive intake assessment. The counselor used the client's reaction to the personal feedback report to promote discussion and bolster the client's motivation to abstain from marijuana use. The information also was used to

reinforce clients' confidence in their ability to end marijuana use and to offer support in goal-setting strategies for behavior change. One month later, the second session reviewed efforts to abstain and the coping skills used in the interim period. In both treatment conditions, participants had the option of involving a support person.

The results showed that both active treatments produced substantial reductions in marijuana use relative to the delayed treatment control condition. Following treatment, there were no differences between the two active treatments in abstinence rates, days of marijuana use, severity of problems, or number of dependence symptoms. Similarly, at the 16-month assessment, 29 percent of group counseling participants and 28 percent of individual counseling participants reported having been abstinent for the past 90 days. The results of this study suggest that minimal interventions consisting of as little as two sessions may be more cost-effective than lengthier treatments.

In another study (Budney et al. 2000), 60 adults who were marijuana dependent were randomly assigned to one of three 14-week treatments: (1) MET, (2) MET plus coping skills training, or (3) MET plus coping skills training and voucher-based incentives. In the last condition, participants whose abstinence from marijuana and other drugs was documented by urinalysis received vouchers that were exchangeable for retail items (e.g., movie passes, sports equipment, educational classes). The value of each voucher increased with each successive instance of confirmed abstinence. Conversely, the occurrence of a cannabinoid-positive urine specimen (or the failure to submit a sample) led to a reduction of each voucher's value to its initial level. The results showed that participants in the voucher-based incentive condition were more likely to achieve continuous abstinence from marijuana during treatment than were participants in the other two conditions. Moreover, a greater percentage of participants in the voucher-based condition (35%) were abstinent at the end of treatment than was the case in the skills training (10%) or MET (5%) conditions.

The results of these studies indicate that a substantial proportion of adults who were marijuana dependent and who sought treatment have been aided in either stopping or decreasing their marijuana use. However, it is also apparent that not all of those treated achieved the initial goal of sustained abstinence from marijuana. Given the evidence of marijuana's dependence potential and adverse health and behavioral consequences, continuing development and testing of marijuana dependence interventions are clearly warranted.

Marijuana Treatment Project

MTP was funded by the Center for Substance Abuse Treatment in 1997 and conducted in three States (Connecticut, Florida, and Washington) over a 3-year period. MTP compared two active treatments with a delayed treatment control condition (Stephens et al. 2002). One active treatment consisted of nine individual counseling sessions delivered over a 12-week period. The initial sessions focused on MET. These were followed by CBT skills training along with additional case management if needed. With some minor modifications, the BMDC described in this manual was based on the nine-session treatment evaluated in MTP. The other active treatment used in MTP consisted of two MET sessions delivered over a 1-month period.

A total of 450 participants from diverse ethnic and socioeconomic backgrounds was recruited through media advertisements and agency referrals. These individuals were primarily male (68%) and on average 36 years old. Sixty-nine percent of the group was white, with 12 percent

African-American, 17 percent Hispanic, and 1 percent other, which included Asian-American, Native American, or unknown (1% is accounted for by rounding error). Approximately 60 percent of the sample was unmarried. Individuals in this group had, on average, 14 years of education. Sixty-nine percent worked full time, 14 percent worked part time, 12 percent were unemployed, and 4 percent were students, retired people, or homemakers (1% is accounted for by rounding error). Those who worked had been employed at their current jobs for approximately 5 years (Stephens et al. 2002).

Ninety-two percent of the study participants felt that they were currently dependent on marijuana. At the time of the screening, almost the entire sample (99.8%) felt that marijuana was the biggest problem for them (relative to other drugs or alcohol). The group reported smoking marijuana on 82 of the past 90 days (91% of the days), smoked an average of 3.7 times a day, and reported that the number of days since their last smoking episode was 1.2. Use of other drugs and alcohol in the past 30 days was infrequent, in part because individuals who were concurrently dependent on alcohol or drugs other than marijuana were ineligible.

The results of MTP showed a consistent pattern of differences between groups. The delayed treatment group changed little from baseline to the 4-month followup on almost all outcome measures. At each followup point over a 12-month period, both active treatments produced outcomes superior to the 4-month delayed treatment control condition. The nine-session intervention produced significantly greater reductions in marijuana use and associated consequences than the two-session intervention. Abstinence rates at the 4- and 9-month followups for the nine-session intervention were 23 percent and 13 percent, respectively. The differences between the two active treatments appeared as early as 4 weeks into the treatment period and were sustained throughout the first 9 months of followup.

As was the case in the findings of the studies discussed above, MTP findings demonstrated a moderate degree of efficacy of counseling interventions with adults who are marijuana dependent. Outcomes from the two-session MET intervention were less positive than those found in the study by Stephens and colleagues (2000), suggesting that the effectiveness of brief and more intensive treatment may vary with the population studied, the content of the therapy, and the skills of the clinicians.

The MTP results indicate that even a brief two-session treatment is associated with substantial reductions in marijuana use and related problems. Nevertheless, a significant percentage of these chronic smokers continue or return to marijuana use, albeit at reduced levels. For example, although the nine-session intervention resulted in a 60-percent reduction in marijuana use up to a year after the end of therapy, it did not produce sufficient abstinence rates to eliminate completely the risk of accidents, injuries, chronic disease, and a return to marijuana dependence. Nevertheless, even with reduced levels of use, both treatments were associated with significant reductions in anxiety levels, legal problems, and employment problems.

It is important to note that, although a substantial percentage of clients did not succeed in becoming abstinent, many individuals remained motivated to overcome their dependence. At the 9-month posttreatment assessment, 82 percent had relapsed and 68 percent indicated that they had tried to stop using marijuana at some point between their 4- and 9-month assessment interviews. These findings suggest that participants who receive a single episode of care remain motivated to change and thus should be followed by aggressive community outreach and support services.

Outreach, Access, and Support Groups

The demonstration of several efficacious treatment interventions for marijuana dependence raises additional questions about how best to engage in treatment people who chronically use marijuana and how best to maintain improvements following treatment. Unfortunately, little research has been conducted in these areas.

Marijuana Anonymous (MA) groups, a mutual-help fellowship based on the principles and traditions of Alcoholics Anonymous (AA), exist in a number of States and internationally. In addition to traditional meetings, MA sessions are held on line. (The organization's Web site address is www.marijuana-anonymous.org. Its toll-free telephone number is 800-766-7669.) No research has been conducted yet to evaluate the effectiveness of MA, either alone or in combination with formal treatment. Nevertheless, research on AA suggests that mutual-help organizations can play an important role in recovery, both alone and in combination with formal treatment programs (McCrady and Miller 1993).

Conclusion

Individuals who use marijuana chronically as their primary drug tend not to seek treatment in traditional drug treatment settings, but it appears from MTP and other studies that when given the opportunity, they respond to treatment. Given the promising initial research on treatment for cannabis dependence and the potential benefits of brief motivational and cognitive behavioral relapse prevention therapies, there is now sufficient evidence to support the development of focused treatment programs for this population. The manual-guided therapies developed for these projects, particularly MTP, should be transferable to specialized outpatient clinics and to behavioral health care practitioners.

Supplemental Reading C: Implementing Brief Marijuana Dependence Counseling

To be effective, BMDC must be implemented in the context of contemporary substance abuse treatment, which has to be integrated with a larger system that takes into account the program setting, referral sources, professional staff, program administration, and linkage to and coordination with ancillary services and with marketing, recruitment procedures, assessment, training, supervision, program administration, and quality assurance. Successful management of a population of people who abuse a different substance requires more than simply adding interventions to an existing treatment system. Ideally, the implementation of a BMDC component to a program will bring with it changes in services, such as recruitment, referrals, case management, initial client contact, therapist training, and administration.

Recruitment

The majority of participants in clinical trials of marijuana dependence treatment (see Supplemental Reading B) contacted the programs in response to newspaper advertising. Advertisements were placed in the news and movie sections of major and alternative newspapers. Some treatment participants said they had taken the study advertisement from the paper and carried it with them for weeks before calling. Other avenues of recruitment included bus advertisements, radio announcements, and newspaper stories about the program. Placing small announcements in places appropriate for different groups, such as beauty parlors, pharmacies, and supermarkets, also may be effective.

Many people who chronically use marijuana believe their problems with its use are unique. In a study of barriers to formal treatment, Copeland (1997) found that although women in general were aware of options for specialized alcohol and drug treatments, this was not true for the women who were dependent on marijuana. These women believed that they were the only people with such a problem, which may have contributed to their reluctance to seek treatment. It also may explain the positive response to the announcements used by MTP, which were gentle and nonthreatening and ensured confidentiality. The announcements read, *Ready to make a change in your marijuana use? Not sure how to go about it? Free, confidential, and nonjudgmental marijuana counseling.* This communicated that

- Potential clients were not alone.
- Experts recognize marijuana use can be a problem and take it seriously.
- A special program for marijuana use problems existed and was readily accessible.

The nonauthoritarian nature of the ad appealed to people using marijuana who were experiencing problems and were ambivalent about their use. Clients who contacted MTP for treatment often commented that the nonjudgmental stance was important in making the offer of assistance attractive to them.

Referrals

The courts and employee assistance programs (EAPs) are both sources of referrals to BMDC. Many communities have drug courts that manage nonviolent drug-related cases. Programs such as BMDC provide the courts with alternatives to incarceration for nonviolent offenders. Persons convicted of possession or driving under the influence of marijuana also may be referred appropriately. EAPs may refer employees who voluntarily present themselves or are identified following a job-related accident. Preemployment screening also leads to treatment seeking when continued marijuana use is perceived as an obstacle to desired employment. Often these referrals result in traditional treatment. However, when EAP counselors are educated about a special research-based program for marijuana use, BMDC may be seen as the treatment of choice.

Court referrals are usually subject to mandatory urine testing for drug use. In Florida between 1994 and 1999, 63 percent of persons entering treatment and reporting their primary drug problem to be marijuana (with no other drug involvement) were involved with the criminal justice system. Although court referrals generally are excluded from marijuana clinical trials, there is no reason to believe that these individuals would not be appropriate for BMDC. The possibility of incarceration is a powerful motivator for change (Hser et al. 1998).

Similarly, persons who are subject to targeted urine testing because of job-related problems may want to enter treatment. Urine testing increases the likelihood that continued use will result in the loss of employment. Thus, to the extent continued employment is important, readiness to change will be greater and ambivalence less strong.

Case Management

Many MTP participants identified case management needs that were nontraditional. Their needs were often related to isolation, health, and time management. Referrals to health clubs,

recreational programs, and religious activities were called for. Clients in serious need of medical care, housing, or legal counseling were rarely encountered. Programs that implement BMDC should develop case management linkages to the community to provide ancillary services, such as vocational counseling, medical treatment, and psychiatric care. BMDC uses a problemsolving approach to case management. Clients may need assistance in addressing barriers to treatment participation and recovery. Case management in the BMDC model provides linkage information rather than advocacy. Cooperative agreements for referral should be in place so that the therapist knows what services are available in the community and how they can be accessed most easily.

Initial Contact With Clients

Receptionists and assessment staff members should be aware of the program's advertisements, public service announcements, or other activities so that they can respond knowledgeably and professionally to telephone inquiries. Research participants report that any initial resistance or confusion by the treatment facility leads to a breakdown in the initiation process. A friendly, empathetic, and understanding atmosphere should begin with the first contact and continue throughout treatment and followup.

If possible, the BMDC component should be assigned its own phone number, and a receptionist answering the phone should respond with that component's name. If an answering system is used, the message can distinguish the BMDC program from others offered by the agency. Callers may raise questions about BMDC's specific components and its track record or demonstrated effectiveness to determine whether it can help them. They may be concerned about whether they will be treated in groups with people who use other drugs (e.g., cocaine) or alcohol. They may be relieved that BMDC specializes in treating "people like them" and pleased to know the program is based on scientific research. Callers need to know that the program is sensitive to their needs, that staff will take them seriously, and that the services are delivered professionally. MTP participants were apprehensive initially and wanted a counselor trained to treat marijuana problems.

Training Staff

The treatment effort begins with the assessment session. Assessment staff should be

- Knowledgeable about marijuana use and its consequences
- Trained to diagnose marijuana dependence and abuse and to document use patterns and related problems
- Sensitive to the ambivalence toward treatment of people who use marijuana
- Trained in MET and how to use the assessment information.

Counselors should be competent in MET, CBT, and case management. Staff members should be selected on the basis of their empathy, warmth, and genuineness, as well as their cognitive style, which should include receptiveness to learning new approaches and willingness to consider that several ways exist to solve a problem. A counselor who lacks empathy and openness to the client's perspective will be ineffective.

Training should include at least three elements:

1. **Training sessions covering principles and practices of MET.** This manual should be distributed in advance of training sessions to introduce basic material and create interest in the BMDC method. The training should include an introduction to the stages of change and the general principles and strategies of MET. A section of the training should be dedicated to the unique characteristics of the marijuana-dependent treatment population. Incompatible treatment methods need to be identified and discussed. Training can be done individually or in a group format.

2. **Regular supervision.** Counselors in training should be required to provide videotapes of themselves using MET, CBT, and case management for trainers and fellow trainees to critique. Many counselors are reluctant to allow themselves to be videotaped. To allay their concern, counselors first should view tapes of their supervisors conducting sessions and rate these tapes. Next, role plays with other counselors can be taped. Finally, counselor–client sessions can be taped and discussed. This gradual exposure appears to relieve anxiety related to taping.

   Trainers should continue to shape performance until counselors demonstrate competence. Training in CBT and case management may take less time and effort than MET training because experienced substance abuse treatment practitioners tend to have been exposed to the two former treatment procedures. Resistance to MET and a manual-guided approach should be expected; opposition sometimes derives from misunderstanding. Many counselors believe that motivational interviewing means cheerleading. Also, many professionals in the addiction field are committed to their approaches to treatment (traditional approaches often are confrontational and directive) and may be reluctant to try a new method, especially if the underlying philosophy differs from one they are most familiar with.

3. **Ensuring the BMDC approach.** Regular supervision is needed to ensure competence. Case conferences and periodic session taping are needed to make certain that counselors follow the BMDC approach correctly. Chart reviews may be conducted systematically as a means of monitoring implementation. In MTP, monthly supervision was sufficient to maintain fidelity to the model. Supervision can be done in several ways. The counselor can provide a videotape of a session to the supervisor, who rates the treatment elements employed (MET, CBT, or case management) using a session rating form similar to the one in appendix A. This form provides the counselor with helpful feedback. It also can be useful to have counselors rate other counselors' tapes, comparing their evaluations with those of their supervisor and discussing how to implement the model in various situations. When rating and scoring taped sessions, counselors' criticism should be gentle, emphasizing what was done right and building on strengths of the counselor being rated.

Two videotapes were created to accompany this treatment manual. The first tape highlights the problem of marijuana dependence in the United States, discusses epidemiology, and contains interviews with key figures who have studied this problem. The second tape uses three hypothetical clients to provide practical information and demonstrations of BMDC at work. These tapes are recommended for counselors, supervisors, and agency administrators who want to use

BMDC to treat people who smoke marijuana. To obtain more information about the BMDC training tapes, please contact Karen Steinberg, Ph.D., Department of Psychiatry, University of Connecticut School of Medicine, 263 Farmington Avenue, Farmington, CT 06030-1410; 860-679-3712.

Administration

From an administrative point of view, a sustainable BMDC program requires at least three counselors to prevent disruption of service delivery. Administrators should provide uninterrupted delivery of BMDC, which may mean training backup personnel in case of resignation, vacation, termination, or prolonged illness.

Sustainability also raises funding issues. Many agencies can use public funding sources to provide BMDC, such as block grants or general revenue funds. Any funding source for outpatient treatment probably can be used for BMDC. Moreover, many persons with marijuana dependence may be willing to pay for treatment out of pocket, especially when weighing the savings that result from stopping their marijuana use.

Another important implementation decision concerns the identity of the program. One option is to offer BMDC as one of many services integrated into a variety of treatments that an agency may offer. However, use of BMDC may increase when it is promoted as a program with its own identity, distinct from other treatment programs, perhaps with its own location, for at least two reasons. First, knowing that a special program exists for people who use marijuana is reassuring to potential clients. Second, confidentiality often is important. Some clients are more comfortable when the program is not identified specifically as a drug treatment center.

Creating a distinct program identity also has the advantage of minimizing staff resistance. It makes it possible to select only those counselors among staff for whom this approach has an appeal or to recruit counselors who are eager to join a new, exciting, cutting-edge program.

APPENDIX A.
Session Rating Form

Please answer the following questions based on the session you observed. Do not complete this form if this was an emergency session.

1. What session topic was covered this week?

   1=Motivational enhancement:

   a. Feedback session
   b. Planning session

   2=Cognitive behavioral (if several topics were addressed, indicate the percentage of the session devoted to the particular topic; be sure total equals 100 percent):

a. Introduction/functional analysis	___	g. Planning for emergencies	___
b. Coping with cravings	___	h. Seemingly irrelevant decisions	___
c. Managing thoughts	___	i. Managing negative moods & depression	___
d. Problemsolving	___	j. Assertiveness	___
e. Refusal skills	___	k. Anger management	___
f. Couples/family involvement	___	l. Other (specify): _____	

   3=Case management (specify primary target areas):

a. Housing/shelter	___	g. Emotional/psychological	___
b. Childcare/parenting	___	h. Legal	___
c. Transportation	___	i. Family problems	___
d. Financial support	___	j. Social problems	___
e. Job training/employment	___	k. Support groups	___
f. Medical	___	l. Other (specify): _____	

2. Did a significant other attend the session?

   1=Yes

   If "Yes," circle spouse/partner, parent, sibling, friend, other (specify): _____

   2=No

Motivational Interventions

3. To what extent did the counselor discuss or address the participant's current commitment to abstinence?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

4. To what extent did the counselor discuss, review, or reformulate the participant's goals for treatment?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

5. To what extent did the counselor encourage the participant to make a commitment to change his or her marijuana use?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

6. Eliciting participant concerns about marijuana use: To what extent did the counselor attempt to elicit self-motivational statements from the participant?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

7. Ambivalence: To what extent did the counselor attempt to focus on the participant's ambivalence about changing his or her level of marijuana use?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

8. Feedback/negative consequences: To what extent did the counselor provide structured feedback about the participant's level of marijuana use or refer to specific negative consequences of marijuana use?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

Cognitive Behavioral Interventions

9. To what extent did the counselor discuss high-risk situations the participant has encountered since the last session and explore coping skills used?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

10. To what extent did the counselor ask the participant to monitor, report, or evaluate specific cognitions associated with marijuana use or related problems?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

11. To what extent did the counselor attempt to teach, model, rehearse, review, or discuss specific skills (e.g., drug refusal, coping with craving, social skills) during the session?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

12. To what extent did the counselor apply a problemsolving strategy to a problem or issue raised during the session (this can include psychosocial problems other than marijuana use, as in the case management module)?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

13. Did the counselor do a role play during this session?

1=Yes

2=No

14. To what extent did the counselor encourage the participant to anticipate any high-risk situations that might be encountered before the next session and formulate appropriate coping strategies for such situations?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

Case Management Interventions

15. To what extent did the counselor attempt to identify, assess, or prioritize psychosocial problems other than marijuana and other substance use?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

16. To what extent did the counselor review the community resource directory during the session or explore what resources are available to the participant to cope with a psychosocial problem?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

17. To what extent did the counselor attempt to develop a support plan with the participant?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

18. To what extent did the counselor apply motivational strategies to bolster the participant's commitment to access needed services and address other psychosocial problems?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

19. To what extent did the counselor monitor or review the participant's progress in implementing the support plan?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

20. To what extent did the counselor praise participant efforts to carry out the support plan?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

21. To what extent did the counselor explore the relationship between identified psychosocial problems and marijuana use?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

General

22. To what extent did the counselor assess the participant's use of marijuana or other substances since the last session?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

23. Assessment of general functioning: To what extent did the counselor assess the participant's general level of functioning in major life spheres (e.g., work, intimate relationships, family life, social life)?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

24. Task assignment: Did the counselor develop one or more specific assignments for the participant to engage in between sessions?

1=Yes

2=No

25. To what extent did the counselor review the participant's reactions to last session's assignment, explore or address any difficulties encountered in carrying out the assignment, or provide a rationale for homework or reinforce the importance of extra-session practice of skills, etc.?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

26. Did the participant do last session's homework?

1=No attempt made

2=Some attempt made

3=Practice exercise completed adequately

9=N/A, not assigned

27. Consistency of problem focus: To what extent did the counselor attempt to keep the session focused on prescribed activities (e.g., by redirecting dialog when it strayed off tasks, organizing the session so defined tasks were covered)?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

Approximately how many minutes of this session were devoted to discussion of topics outlined in the manual?

_____ minutes

28. Continuity/reference to past sessions: To what extent did the counselor refer to material discussed in past sessions as a means of building continuity across sessions?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

29. Reflective listening: To what extent did the counselor communicate understanding of the participant's comments and concerns?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

30. Empathy: To what extent did the counselor respond empathetically to the participant (e.g., through a nonjudgmental stance, showing genuine warmth and concern, helping the participant feel accepted in the relationship)?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

31. Family support: To what extent did the counselor inquire about or discuss the availability and nature of family support for the participant's involvement in treatment or efforts to become abstinent?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

32. Termination: To what extent did the counselor discuss the termination of the therapy (e.g., encourage the participant to discuss his or her feelings or thoughts about termination, discuss plans for the continuation of treatment after the end of the protocol)?

1 - - - - - - - - - - 2 - - - - - - - - - - 3 - - - - - - - - - - 4 - - - - - - - - - - 5

not at all a little somewhat considerably extensively

APPENDIX B.
CONTRIBUTORS

Thomas F. Babor, Ph.D., M.P.H
Department of Community Medicine and Health Care
University of Connecticut School of Medicine
Farmington, CT
Writer, sections I and VII

Kathleen M. Carroll, Ph.D.
Department of Psychiatry
Yale University
New Haven, CT
Writer, sections II and VI

Kenneth Christiansen, Psy.D.
Department of Epidemiology and Public Health
University of Miami
Coral Gables, FL
and
The Village South
Miami, FL
Writer, section IV

Carol Davidson, M.S.W.
Evergreen Treatment Services
Seattle, WA
Writer, section VI

David Duresky, M.A.
Children Services Council of Broward County
Plantation, FL
Writer, sections I, V, VI, and VII

Elise Kabela, Ph.D.
Department of Psychiatry
University of Connecticut School of Medicine
Farmington, CT
Writer, sections III, IV, V, and VI

Ronald Kadden, Ph.D.
Department of Psychiatry
University of Connecticut School of Medicine
Farmington, CT
Writer, sections III, V, and VI

Sean McParland, M.P.H., M.S.W.
The Leukemia & Lymphoma Society
White Plains, NY
Writer, section VI

Bonnie McRee, M.P.H.
Department of Community Medicine and Health Care
University of Connecticut School of Medicine
Farmington, CT
Writer, sections I and IV

Michael Miller, Ph.D.
Department of Epidemiology and Public Health
University of Miami
Coral Gables, FL
and
The Village South
Miami, FL
Writer, sections V, VI, and VII

Roger A. Roffman, D.S.W.
Innovative Programs Research Group
University of Washington School of Social Work
Seattle, WA
Writer, sections I, V, VI, and VII

Susan Sampl, Ph.D.
Department of Psychiatry
University of Connecticut Health Center
Farmington, CT
Writer, sections III and VI

Meleney Scudder, Psy.D.
Department of Community Medicine and Health Care
University of Connecticut School of Medicine
Farmington, CT
Writer, sections III and VI

Karen L. Steinberg, Ph.D.
Department of Psychiatry
University of Connecticut School of Medicine
Farmington, CT
Writer, sections II, V, and VI

Robert Stephens, Ph.D.
Department of Psychology
Virginia Tech University
Blacksburg, VA
Writer, sections I, IV, and VII

Janice Vendetti, M.P.H.
Department of Community Medicine and Health Care
University of Connecticut School of Medicine
Farmington, CT
Writer, section IV

APPENDIX C.
Field Reviewers

Rosie Anderson-Harper, M.A.
Mental Health Manager
Missouri Department of Mental Health
Division of Alcohol and Drug Abuse
Jefferson City, MO

Gilberte M. Berry, LADC
Substance Abuse Counselor and Case Manager
Community Concepts, Inc.
Auburn, ME

Jeff Bickford, M.A., LADC
Manager
Maine General Medical Center
Waterville, ME

Stephen P. Bogan, M.A., NCAC II
Youth Treatment Services Lead
Division of Alcohol and Substance Abuse
Olympia, WA

Judith A. Booker, LPC, CSAC
Therapist III
Alexandria Community Services Board
Alexandria, VA

Marty Estrada
Certified Addiction Specialist
Human Services Agency
County of Ventura
Ventura, CA

Paul Fergeson, M.A., CSAC
Counselor III
Norfolk Community Services Board
Norfolk, VA

María del Mar García-Rodriguez, M.S.W., M.S.H.
Continuing Education Coordinator
Caribbean Basin and Hispanic Addiction Technology Transfer Center
Universidad Central del Caribe
Bayamon, PR

Carmen E. Greiner, M.S., LPC, LSATP, MAC
Mental Health and Substance Abuse Therapist
Rappahanock Area Community Services Board
Spotsylvania, VA

Jaime Henao, CSAC
Therapist III
Alexandria Community Services Board
Alexandria, VA

Stuart McElfresh, LCSW
Alexandria Community Services Board
Alexandria, VA

Virginia Ochoa, CAC III
Cultural Services Manager
Arapahoe House, Inc.
Commerce City, CO

Karen Redford, CAC, CCS, NCAC II
Adult Substance Abuse Services Coordinator
Richmond Behavioral Health Authority
Richmond, VA

Susan Tatum, LCSW
Substance Abuse Counselor and Case Manager
Alexandria Community Services Board
Alexandria, VA

REFERENCES

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Washington, DC: American Psychiatric Press, 1994.

Andreasson, S.; Allebeck, P.; Engstrom, A.; and Rydberg, U. Cannabis and schizophrenia: A longitudinal study of Swedish conscripts. *Lancet* 2(8574):1483–1486, 1987.

Annis, H.M. *Situational Confidence Questionnaire (SCQ) User's Guide.* Toronto, Ontario, Canada: Marketing Services, Addiction Research Foundation, 1988.

Anthony, J.C., and Helzer, J.E. Syndromes of drug abuse and dependence. In: Robins, L.N., and Regier, D.A., eds. *Psychiatric Disorders in America*. New York: Free Press, 1991, pp. 116–154.

Anthony, J.C.; Warner, L.A.; and Kessler, R.C. Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants: Basic findings from the national comorbidity survey. *Experimental and Clinical Psychopharmacology* 2:244–268, 1994.

Bedell, J.R.; Archer, R.P.; and Marlowe, H. A description and evaluation of a problem solving skills training program. In: Upper, D., and Ross, S.M., eds. *Behavioral Group Therapy: An Annual Review.* Champaign, IL: Research Press, 1980.

Block, R.I., and Ghoneim, M.M. Effects of chronic marijuana use on human cognition. *Psychopharmacology* 110(1–2):219–228, 1993.

Budney, A.J.; Higgins, S.T.; Radonovich, K.J.; and Novy, P.L. Adding voucher-based incentives to coping-skills and motivational enhancement improves outcomes during treatment for marijuana dependence. *Journal of Consulting and Clinical Psychology* 68(6):1051–1061, 2000.

Budney, A.J.; Hughes, J.R.; Moore, B.A.; and Novy, P.L. Marijuana abstinence effects in marijuana smokers maintained in their home environment. *Archives of General Psychiatry* 58(10):917–924, 2001.

Budney, A.J.; Novy, P.L.; and Hughes, J.R. Marijuana withdrawal among adults seeking treatment for marijuana dependence. *Addiction* 94(9):1311–1321, 1999.

Budney, A.J.; Radonovich, K.J.; Higgins, S.T.; and Wong, C.J. Adults seeking treatment for marijuana dependence: A comparison to cocaine-dependent treatment seekers. *Experimental and Clinical Psychopharmacology* 6(4):1–8, 1998.

Carroll, K.M. *A Cognitive-Behavioral Approach: Treating Cocaine Addiction.* NIH Publication 98–4308. Rockville, MD: National Institute on Drug Abuse, 1998, reprinted 2000 and 2002.

Chesher, G. Cannabis and road safety: An outline of research studies to examine the effects of cannabis on driving skills and actual driving performance. In: *The Effects of Drugs (Other Than Alcohol) on Road Safety.* Melbourne, Australia: Road Safety Committee, Parliament of Victoria, 1995, pp. 67–96.

Clark, H.W.; Horton, A.M., Jr.; Dennis, M.; and Babor, T.F. Moving from research to practice just in time: The treatment of cannabis use disorders come of age. *Addiction* 97(Suppl. 1):1–3, 2002.

Coffey, C.; Carlin, J.B.; Degenhardt, L.; Lynskey, M.; Sanci, L.; and Patton, G.C. Cannabis dependence in young adults: An Australian population study. *Addiction* 97(2):187–194, 2002.

Compton, D.R.; Dewey, W.L.; and Martin B.R. Cannabis dependence and tolerance production. *Advances in Alcohol and Substance Abuse* 9(1–2):128–147, 1990.

Compton, W.M.; Grant, B.F.; Colliver, J.D.; Glantz, M.D.; and Stinson, F.S. Prevalence of marijuana use disorders in the United States: 1991–1992 and 2001–2002. *JAMA* 291(17):2114–2121, 2004.

Copeland, J. A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviors. *Journal of Substance Abuse Treatment* 14(2):186, 1997.

Crowley, T.J.; Macdonald, M.J.; Whitmore, E.A.; and Mikulich, S.K. Cannabis dependence, withdrawal, and reinforcing effects among adolescents with conduct symptoms and substance use disorders. *Drug and Alcohol Dependence* 50(1):27–37, 1998.

CSAT (Center for Substance Abuse Treatment). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

CSAT (Center for Substance Abuse Treatment). *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99-3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*a*.

CSAT (Center for Substance Abuse Treatment). *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 00-3460. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*b*, reprinted 2000.

CSAT (Center for Substance Abuse Treatment). *KAP Keys for Clinicians Based on TIP 34*. DHHS Publication No. (SMA) 01-3601. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001*a*.

CSAT (Center for Substance Abuse Treatment). *Quick Guide for Clinicians Based on TIP 34*. DHHS Publication No. (SMA) 01-3600. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001*b*.

CSAT (Center for Substance Abuse Treatment). *KAP Keys for Clinicians Based on TIP 35.* DHHS Publication No. (SMA) 01-3603. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001*c*.

CSAT (Center for Substance Abuse Treatment). *Quick Guide for Clinicians Based on TIP 35.* DHHS Publication No. (SMA) 01-3602. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001*d*.

Day, N.L.; Richardson, G.A.; Goldschmidt, L.; Robles, N.; Taylor, P.M.; Stoffer, D.S.; Cornelius, M.D.; and Geva, D. Effect of prenatal marijuana exposure on the cognitive development of offspring at age three. *Neurotoxicology and Teratology* 16(2):169–175, 1994.

Devane, W.A.; Hanus, L.; Breuer, A.; Pertwee, R.G.; Stevenson, L.A.; Griffin, G.; Gibson, D.; Mandelbaum, A.; Etinger, A.; and Mechoulam, R. Isolation and structure of a brain constituent that binds to the cannabinoid receptor. *Science* 258(5090):1946–1949, 1992.

Donald, P.J. Advanced malignancy in the young marijuana smoker. In: Freidman, H.; Specter, S.; and Klein, T.W., eds. *Drugs of Abuse, Immunity, and Immunodeficiency.* London: Plenum Press, 1991, pp. 33–46.

D'Zurilla, T.J., and Goldfried, M.R. Problem solving and behavior modification. *Journal of Abnormal Psychology* 78:107–126, 1971.

Emery, G. *A New Beginning: How To Change Your Life Through Cognitive Therapy.* New York: Simon and Schuster, 1981.

First, M.B.; Spitzer, R.; Gibbon, M.; and Williams, J. *Structured Clinical Interview for DSM-IV*. New York: Biometrics Research Department, New York State Psychiatric Institute, 1996.

First, M.B.; Spitzer, R.L.; Williams, J.B.W.; and Gibbon, M. Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). In: American Psychiatric Association (APA), *Handbook of Psychiatric Measures.* Washington, DC: APA, 2000, pp. 49–53.

Godley, S.H.; Meyers, R.J.; Smith, J.E.; Karvinen, T.; Titus, J.C.; Godley, M.D.; Dent, G.; Passetti, L.; and Kelberg, P. *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 4. DHHS Publication No. (SMA) 01-3489. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Grenyer, B.; Solowij, N.; and Peters, R. *A Guide to Quitting Marijuana.* Sydney, Australia: University of New South Wales, 1995.

Haas, A.P., and Hendin, H. The meaning of chronic marijuana use among adults: A psychosocial perspective. *Journal of Drug Issues* 17:333–348, 1987.

Hall, W. The public health implications of cannabis use. *Australian Journal of Public Health* 19:235–242, 1995.

Hall, W., and Babor, T.F. Cannabis use and public health: Assessing the burden. *Addiction* 95:485–490, 2000.

Hall, W.; Johnston, L.; and Donnelly, N. Epidemiology of cannabis use and its consequences. In: Kalant, H.; Corrigall, W.A.; Hall, W.; and Smart, R. eds. *The Health Effects of Cannabis.* Toronto, Ontario, Canada: Addiction Research Foundation, 1999, pp. 71–125.

Hall, W., and Solowij, N. The adverse effects of cannabis use. *Lancet* 352(9140):1611–1616, 1998.

Hamilton, N.L.; Brantley, L.B.; Tims, F.M.; Angelovich, N.; and McDougall, B. *Family Support Network for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 3. DHHS Publication No. (SMA) 01-3488. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Haney, M.; Ward, A.S.; Comer, S.D.; Foltin, R.W.; and Fischman, M.W. Abstinence symptoms following oral THC administration in humans. *Psychopharmacology* 141(4):385–394, 1999*a*.

Haney, M.; Ward, A.S.; Comer, S.D.; Foltin, R.W.; and Fischman, M.W. Abstinence symptoms following smoked marijuana in humans. *Psychopharmacology* 141(4):395–404, 1999*b*.

Hatch, E.E., and Bracken, M.B. Effect of marijuana use in pregnancy on fetal growth. *American Journal of Epidemiology* 124(6):986–993, 1986.

Hollister, L.E. Health aspects of cannabis. *Pharmacological Reviews* 38(1):1–20, 1986.

Hser, Y.; Maglione, M.; Polinsky, M.; and Anglin, M. Predicting drug treatment entry among treatment-seeking individuals. *Journal of Substance Abuse Treatment* 15(3):213–220, 1998.

Intagliata, J.C. Increasing the responsiveness of alcoholics to group therapy: An interpersonal problem-solving approach. *Group* 3:106–120, 1979.

Jones, R.T., and Benowitz, N. The 30-day trip: Clinical studies of cannabis tolerance and dependence. In: Braude, M.C., and Szara, S. eds. *Pharmacology of Marijuana.* Volume 2. Orlando, FL: Academic Press, 1976, pp. 627–642.

Kadden, R.; Carroll, K.; Donovan, D.; Cooney, N.; Monti, P.; Abrams, D.; Litt, M.; and Hester, R., eds. *Cognitive-Behavioral Coping Skills Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence.* Project MATCH Monograph Series, Volume 3. NIH Publication No. (ADM) 94-3724. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1994.

Kandel, D.C., and Davies, M. Progression to regular marijuana involvement: Phenomenology and risk factors for near daily use. In: Glantz, M., and Pickens. R. eds. *Vulnerability to Drug Abuse.* Washington, DC: American Psychological Association, 1992, pp. 211–253.

Kouri, E.M., and Pope, H.G., Jr. Abstinence symptoms during withdrawal from chronic marijuana use. *Experimental and Clinical Psychopharmacology* 8(4):483–492, 2000.

Liddle, H.A. *Multidimensional Family Therapy for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 5. DHHS Publication No. (SMA) 02-3660. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Lundqvist, T. Specific thought patterns in chronic cannabis smokers observed during treatment. *Life Sciences* 56(23–24):2141–2144, 1995.

MacPhillamy, D.J., and Lewinsohn, P.M. The pleasant events schedule: Studies on reliability, validity, and scale intercorrelation. *Journal of Consulting and Clinical Psychology* 50:363–380, 1982.

Marlatt, G.A., and Gordon, J.R. *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors.* New York: Guilford Press, 1985.

McBride, C.M.; Curry, S.J.; Stephens, R.S.; Wells, E.A.; Roffman, R.A.; and Hawkins, J.D. Intrinsic and extrinsic motivation for change in cigarette smokers, marijuana smokers, and cocaine users. *Psychology of Addictive Behaviors* 8:243–250, 1994.

McCrady, B.S., and Miller, W.R. eds. *Research on Alcoholics Anonymous: Opportunities and Alternatives.* New Brunswick, NJ: Rutgers Center on Alcohol Studies, 1993.

Miller, W.R. *Form 90. A Structured Assessment Interview for Drinking and Related Behaviors. Test Manual.* Project MATCH Monograph Series, Volume 5. NIH Publication Number 96–4004. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1996.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People for Change,* Second Edition. New York: Guilford Press, 2002.

Monti, P.M.; Abrams, D.B.; Kadden, R.M.; and Cooney, N.L. *Treating Alcohol Dependence: A Coping Skills Training Guide.* New York: Guilford Press, 1989.

MTP Research Group. Treating cannabis dependence: Findings from a randomized trial. *Journal of Consulting and Clinical Psychology,* in press.

Pertwee, R.G. Cannabinoid receptors and their ligands in brain and other tissues. In: Nahas, G.G.; Sutin, K.M.; Harvey, D.J.; and Agurell, S., eds. *Marijuana and Medicine.* Totowa, NJ: Humana Press, 1999, pp. 187–195.

Pope, H.G.; Gruber, A.J.; and Yurgelun-Todd, D. The residual neuropsychological effects of cannabis: The current status of research. *Drug and Alcohol Dependence* 38(1):25–34, 1995.

Prochaska, J., and DiClemente, C.C. Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice* 19(3):276–288, 1982.

Prochaska, J.; DiClemente, C.C.; and Norcross, J. In search of how people change. *American Psychologist* 47(9):1102–1114, 1992.

Rainone, G.A.; Deren, S.; Kleinman, P.H.; and Wish, E.D. Heavy marijuana users not in treatment: The continuing search for the "pure" marijuana user. *Journal of Psychoactive Drugs* 19(4):353–359, 1987.

Richardson, G.A.; Day, N.L.; and Goldschmidt, L. Prenatal alcohol, marijuana, and tobacco use: Infant mental and motor development. *Neurotoxicology and Teratology* 17(4):479–487, 1995.

Rinaldi-Carmona, M.; Barth, F.; Heaulme, M.; Shire, D.; Calandra, B.; Congy, C.; Martinez, S.; Maruani, J.; Neliat, G.; Caput, D.; Ferrara, P.; Soubrie, P.; Breliere, J.C.; and LeFur, G. SR 141716A, a potent and selective antagonist of the brain cannabinoid receptor. *FEBS Letters* 350(2–3):240–244, 1994.

Robbe, H.W.J. *Influence of Marijuana on Driving.* Maastricht, The Netherlands: Institute for Human Psychopharmacology, University of Limberg, 1994.

Roffman, R.A., and Barnhart, R. Assessing need for marijuana dependence treatment through an anonymous telephone interview. *International Journal of the Addictions* 22(7):639–651, 1987.

Roffman, R.A.; Stephens, R.S.; Simpson, E.E.; and Whitaker, D.L. Treatment of marijuana dependence: Preliminary results. *Journal of Psychoactive Drugs* 20(1):129–137, 1988.

Rosenberg, M.F., and Anthony, J.C. Early clinical manifestations of cannabis dependence in a community sample. *Drug and Alcohol Dependence* 64(2):123–131, 2001.

Sampl, S.A., and Kadden, R. *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions.* Cannabis Youth Treatment Series, Volume 1. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Sanchez-Craig, M. "A Counselor's Manual for Secondary Prevention of Alcohol Problems." Unpublished manual. Toronto, Ontario, Canada: Addiction Research Foundation, 1983.

Scher, M.S.; Richardson, G.A.; Coble, P.A.; Day, N.L.; and Stoffer, D. The effects of prenatal alcohol and marijuana exposure: Disturbances in sleep cycling and arousal. *Pediatric Research* 24(1):101–105, 1988.

Smiley A. Marijuana: On road and driving simulator studies. In: Kalant, H.; Corrigall, W.; Hall, W.; and Smart, R. eds. *The Health Effects of Cannabis.* Toronto, Ontario, Canada: Addiction Research Foundation, 1999.

Sobell, L.C., and Sobell, M.B. Timeline follow-back: A technique for assessing self reported alcohol consumption. In: Litten, R.Z., and Allen, J.P., eds. *Measuring Alcohol Consumption: Psychological and Biochemical Methods.* New Jersey: Humana Press, 1992, pp. 41–72.

Sobell, L.C., and Sobell, M.B. Alcohol Timeline Followback (TLFB). In: American Psychiatric Association (APA). *Handbook of Psychiatric Measures.* Washington, DC: APA, 2000, pp. 477–479.

Sobell, L.C., and Sobell, M.B. Alcohol consumption measures. In: Allen, J.P., and Wilson, V., eds. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers,* Second Edition. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 2003.

Sobell, L.C.; Sobell, M.B.; Connors, G.; and Agrawal, S. Is there one self-report drinking measure that is best for all sessions? *Alcoholism: Clinical and Experimental Research,* forthcoming.

Solowij, N. *Cannabis and Cognitive Functioning.* New York: Cambridge University Press, 1998.

Solowij, N.; Michie, P.T.; and Fox, A.M. Effects of long-term cannabis use on selective attention: An event-related potential study. *Pharmacology Biochemistry and Behavior* 40(3):683–688, 1991.

Steinberg, K.L.; Roffman, R.A.; Carroll, K.M.; Kabela, E.; Kadden, R.; Miller, M.; Duresky, D.; and The Marijuana Treatment Project Research Group. Tailoring cannabis dependence treatment for a diverse population. *Addiction* 97(Suppl. 1):135–142, 2002.

Stephens, R.S.; Babor, T.F.; Kadden, R.; Miller, M.; and the Marijuana Treatment Project Group. The Marijuana Treatment Project: Rationale, design, and participant characteristics. *Addiction* 97(Suppl. 1):109–124, 2002.

Stephens, R.S., and Roffman, R.A. Adult marijuana dependence. In: Baer, J.S.; Marlatt, G.A.; and McMahon, J., eds. *Addictive Behaviors Across the Lifespan: Prevention, Treatment, and Policy Issues.* Newbury Park, CA: Sage, 1993, pp. 202–218.

Stephens, R.S.; Roffman, R.A.; Burke, R.; Williams, C.; Balmer, A.; Picciano, J.; and Adams, S. "The Marijuana Check-Up." Paper presented at the annual conference of the Association for Advancement of Behavior Therapy, Washington, DC, November 1998.

Stephens, R.S.; Roffman, R.A.; Cleveland, B.; Curtin, L.; and Wertz, J.S. "Extended Versus Minimal Intervention With Marijuana Dependent Adults." Paper presented at the annual conference of the Association for the Advancement of Behavior Therapy, San Diego, CA, 1994*a*.

Stephens, R.S.; Roffman, R.A.; and Curtin, L. Comparison of extended versus brief treatments for marijuana use. *Journal of Consulting and Clinical Psychology* 68(5):898–908, 2000.

Stephens, R.S.; Roffman, R.A.; and Simpson, E.E. Adult marijuana users seeking treatment. *Journal of Consulting and Clinical Psychology* 61(6):1100–1104, 1993*a*.

Stephens, R.S.; Roffman, R.A.; and Simpson, E.E. Treating adult marijuana dependence: A test of the relapse prevention model. *Journal of Consulting and Clinical Psychology* 62(1):92–99, 1994*b*.

Stephens, R.S.; Wertz, J.S.; and Roffman, R.A. Predictors of marijuana treatment outcomes: The role of self-efficacy. *Journal of Substance Abuse* 5(4):341–354, 1993*b*.

Stephens, R.S.; Wertz, J.S.; and Roffman, R.A. Self-efficacy and marijuana cessation: A construct validity analysis. *Journal of Consulting and Clinical Psychology* 63(6):1022–1031, 1995.

Substance Abuse and Mental Health Services Administration (SAMHSA). *1999 National Household Survey on Drug Abuse Public Use File*. Rockville, MD: Office of Applied Studies, SAMHSA, 2001.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Overview of Findings From the 2002 National Survey on Drug Use and Health*. NHSDA Series H-21, DHHS Publication No. (SMA) 03–3774. Rockville, MD: Office of Applied Studies, SAMHSA, 2003.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Results From the 2003 National Survey on Drug Use and Health: National Findings.* NSDUH Series H-25, DHHS Publication No. (SMA) 04–3964. Rockville, MD: Office of Applied Studies, SAMHSA, 2004.

Swift, W.; Hall, W.; and Copeland, J. Characteristics of long-term cannabis users in Sydney, Australia. *European Addiction Research* 4(4):190–197, 1998*a*.

Swift, W.; Hall, W.; Didcott, P.; and Reilly, D. Patterns and correlates of cannabis dependence among long-term users in an Australian rural area. *Addiction* 93(8):1149–1160, 1998*b*.

Tashkin, D. Cannabis effects on the respiratory system. In: Kalant, H.; Corrigall, W.; Hall, W.; and Smart, R., eds. *The Health Effects of Cannabis.* Toronto, Ontario, Canada: Addiction Research Foundation, 1999, pp. 311–345.

Taylor, F.M. Marijuana as a potential respiratory tract carcinogen: A retrospective analysis of a community hospital population. *Southern Medical Journal* 81(10):1213–1216, 1988.

Thornicroft, G. Cannabis and psychosis: Is there epidemiological evidence for association? *British Journal of Psychiatry* 157:25–33, 1990.

Vendetti, J.; McRee, B.; Miller, M.; Christiensen, K.; Herrell, J.; and the Marijuana Treatment Project Research Group. Correlates of pretreatment dropout among persons with marijuana dependence. *Addiction* 97(Suppl. 1):125–134, 2002.

Webb, C.; Scudder, M.; Kaminer, Y.; and Kadden, R. *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users.* DHHS Publication No. (SMA) 02-3659. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Wert, R.C., and Raulin, M.L. The chronic cerebral effects of cannabis use: I. Methodological issues and neurological findings. *International Journal of the Addictions* 21(6):605–628, 1986*a*.

Wert, R.C., and Raulin, M.L. The chronic cerebral effects of cannabis use: II. Psychological findings and conclusions. *International Journal of the Addictions* 21(6):629–642, 1986*b*.

Wiesbeck, G.A.; Schuckit, M.A.; Kalmijn, J.A.; Tipp, J.E.; Bucholz, K.K.; and Smith, T.L. An evaluation of the history of a marijuana withdrawal syndrome in a large population. *Addiction* 91(10):1469–1478, 1996.

Zhang, Z.; Morgenstern, H.; Spitz, M.R.; Tashkin, D.P.; Yu, G.; Marshall, J.R.; Hsu, T.C.; and Schantz, S. Marijuana use and increased risk of squamous cell carcinoma of the head and neck. *Cancer Epidemiology, Biomarkers and Prevention* 8(12):1071–1078, 1999.

Zuckerman, B.; Frank, D.; Hingson, R.; Amaro, H.; Levenson, S.; Kayne, H.; Parker, S.; Vinci, R.; Aboagye, K.; Fried, L.; Cabral, H.; Timperi, R.; and Bauchner, H. Effects of maternal marijuana and cocaine use on fetal growth. *New England Journal of Medicine* 320(12):62–768, 1989.

Zweben, J.E., and O'Connell, K. Strategies for breaking marijuana dependence. *Journal of Psychoactive Drugs* 20(1):121–127, 1988.

DHHS Publication No. (SMA) 05-4022
NCADI BKD520
Printed 2005