A brief cognitive-behavioural intervention for cannabis dependence: Therapists' treatment manual

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A BRIEF COGNITIVE-BEHAVIOURAL INTERVENTION FOR CANNABIS DEPENDENCE: THERAPISTS' TREATMENT MANUAL

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1. INTRODUCTION
COGNITIVE-BEHAVIOUR THERAPY: AN OVERVIEW

Cognitive-behaviour therapy (CBT) is a general psychological therapeutic technique which was designed to promote more-or-less permanent behaviour change by assisting clients to develop and use specific skills or techniques to overcome a psychological disorder. This approach has been used in the treatment of a wide range of psychological disorders, and was developed from a merging of behaviour therapy in the 1960s and cognitive therapy in the 1970s. From its beginning as a therapy for mood and anxiety disorders, CBT has developed into a multi-purpose therapy, which, among its many applications, has been found to be particularly effective in the management of substance abuse disorders.

CBT is an empirically-based therapy, which works on the premise that cognitions and behaviours are often intrinsically linked. Learning strategies to modify or manage both cognitions and their associated behaviours should yield results that are greater than the effect of targeting one of them alone. Substance abuse disorders, like many psychological disorders, are partly the result of faulty or irrational thought processes that have their manifestation in dysfunctional behaviours, such as drug taking. Many such thoughts are automatic, habitual and resistant to change. The development of techniques to change or challenge such thought processes, together with other cognitive and behavioural coping responses, can lead to a reduction in an individual's dependence on a drug. Thus, CBT is a skills-based approach, and works on helping clients to develop a range of therapeutic techniques for overcoming physiological dependence and habitual reliance on a drug as a coping mechanism. The approach is structured and goal-oriented, with "homework" tasks, which require the client to develop specific skills in the context of their problem drug use by practising set exercises.

The CBT approach is a relatively brief therapeutic intervention, especially when compared with some other psychological therapies. CBT for substance abuse disorders can have an effective impact with one to six sessions (Mattick & Jarvis, 1993). Furthermore, CBT is ideal for therapy with individual clients, as the specific skills or techniques used, can be varied according to the needs of the individual client.

The emphasis of skills training is to help clients to unlearn old habits and replace those with new, more functional skills. Many drug dependent clients have drug use as their primary coping mechanism for a range of situations. CBT allows the clients to develop, under clinical supervision, new coping skills, or to re-establish old skills that have become neglected through lack of use. In addition, other problems that may themselves have prompted drug use as a coping mechanism may gradually be overcome using effective coping strategies.

There are several important elements involved in achieving a successful therapeutic outcome with CBT. First among these is the need to motivate clients to become abstinent from drug use. This is achieved using a motivational interviewing intervention (eg. Miller & Rollnick, 1991). This primarily involves a decisional analysis, whereby clients are assisted to critically examine the pros and the cons of continued drug use. Second, clients are instructed in the use of drug-

related coping skills. These include techniques for managing urges and cravings, recognising triggers for drug use and developing personal strategies for either avoiding or dealing with such triggers, managing withdrawal symptoms, and learning relapse prevention strategies. Third, the program introduces general coping skills, including techniques for managing negative affect, stress management skills, assertiveness and communication skills training, and relaxation skills.

The present intervention is intended to provide an efficacious, brief intervention for clients with cannabis dependence disorder. While it is designed specifically for cannabis problems, the general therapeutic approach uses a standard CBT framework. As such, it is ideal for use by health care professionals skilled in cognitive-behavioural counselling techniques, and preferably also with knowledge of substance abuse issues. It should be noted that these criteria do not limit the users of this program only to clinical psychologists. General medical practitioners, clinical nurse consultants, and social and other health care workers with appropriate backgrounds will find this intervention a useful addition to their clinical resources.

1.1 Cannabis dependence

Cannabis is the generic name given to the collection of materials derived from the plant *Cannabis sativa*. These materials are obtained from various parts of the plant, chiefly the flowering buds and surrounding leaves obtained from the upper extremities of the mature plant. The buds, or "heads" are rich in a sticky, resinous substance which contains high concentrations of cannabinoid compounds. Although there have been numerous cannabinoids identified in the cannabis plant, the primary psychoactive constituent is a single cannabinoid named delta-9-tetrahydrocannabinol (THC). THC is to cannabis as nicotine is to tobacco: different plants and plant strains of varying quality may yield differing quantities of THC, and the means of both preparation and administration of the cannabis plant material influences the amount of THC available to the consumer. Ultimately, in producing the primary psychoactive effects of cannabis consumption, THC, like nicotine, is the substance primarily responsible for the development of cannabis dependence.

While the generic term cannabis is used in this manual, there are a number of terms applied to the substance. The foremost is marijuana, and common terms also include dope, mull, pot, weed and grass. Forms of cannabis grown hydroponically (ie in an enriched substrate without soil) are known as hydro, and one recent popular hybrid form is known as skunk.

1.2 Forms of cannabis

Cannabis is predominantly administered by smoking, and so the form of cannabis used is prepared with the aim of maximising the amount of THC available in the smoke of the burnt plant matter. This is usually achieved by smoking the dried resinous buds and upper leaves of the plant. Cannabis heads are more favoured for their potency. Some users, however, smoke the bulky cannabis leaf, which has low THC levels and usually delivers a harsh, acrid smoke owing to the high levels of tar and other substances present in the burnt plant material.

Alternative forms which deliver greater concentrations of THC include hashish (or "hash"), which is a crude extraction of cannabis resin, compressed in blocks for

consumption by smoking. A relatively unusual form of cannabis is the highly purified oil extracted from hashish, which may contain as much as 60% THC. This is also smoked, after a small amount is added to a tobacco cigarette or pipe.

1.3 Methods of use of cannabis

The primary form of cannabis administration is of course, via smoking. All forms of cannabis product, including leaf, heads, hashish and hash oil can be consumed with the greatest degree of pharmacological efficiency by smoking. Perhaps the best known form of cannabis smoking is via the "joint" or hand-rolled cannabis cigarette. This may be prepared with or without a quantity of tobacco. However, the most popular method of administration, owing to its high degree of efficiency in delivering the greatest amount of THC with little wastage of sidestream smoke, is the water pipe, or "bong" (National Drug Strategy, 1996). The bong is usually made of a small bottle or jar half filled with water. This allows the cannabis smoke to be cooled as it is drawn from the "cone" through the water-filled chamber in a single, maximal inhalation. Heads, leaf and hash may all be consumed via a joint or a bong. recent research has shown that while bongs maximise the amount of THC consumed, they also increase the amount of tar and other harmful materials consumed per dose, compared with joints (Australian Government Analytical Laboratories, 1996). Some smokers make use of conventional small pipes (known as a "chillum"), which also allow for high efficiency in the delivery of THC to the smokers.

It is important to note that THC can also be delivered effectively via other routes. These usually involve preparing cannabis heads or hash in small cakes or cookies and eating them, or suffusing cannabis material in hot water and drinking the resulting brew. While these methods provide satisfactory psychoactive effects, they are not popular with most cannabis users because the time to onset of the effect is much slower than smoking, and the dose is more difficult to judge. On the other hand, oral administration of cannabis offers the advantage of reducing one of the primary medical risks facing most cannabis users: diseases of the respiratory tract.

1.4 Cannabis dependence

Like most other psychoactive substances which produce euphoric effects, the regular, heavy use of cannabis may result in a cannabis dependence syndrome. While the existence of cannabis dependence has been a contentious issue for some years, there is now a growing body of evidence that suggests there is a cannabis dependence syndrome which is consistent with that of other classic drugs of dependence. Certainly, regular use of cannabis produces a marked tolerance, similar to other drugs of abuse and dependence. However, there is now evidence that cannabis also produces that other major characteristic of drug dependence, a withdrawal syndrome Hall, Solowij & lemon, 1994). The general descriptive criteria developed by Edwards, Arif and Hodgson (1981) to apply to all drug dependencies, are also applicable to cannabis (Swift, Copeland & Hall, 1997). This is reflected in the most recent World Health Organisation's (WHO) International Classification of Diseases (ICD-10; 1992) and the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV; 1994). These nosologies allow the operationalisation of the dependence syndrome by defining several basic criteria which reflect the salience with which the user has come to place on the use of the drug, above other behaviours.

Research on large samples of long term cannabis users in Australia has confirmed the appropriateness of the DSM-IV criteria for diagnosing cannabis dependence. In a study of 268 long term, heavy cannabis users from the North Coast area of New South Wales, just over half of the sample met DSM III-R criteria for cannabis dependence. The most common symptoms included: frequent intoxication r use during daily activities, tolerance, and continued use despite problems (Didcott, Reilly, Swift & Hall, 1997). The quantity of cannabis typically used by the study participants was correlated with their degree of cannabis dependence. This sample comprised males and females in their late thirties to early forties, who had been using cannabis on average for 19 years. Only a small proportion had used alcohol in a harmful manner, although almost all had used tobacco regularly. The sample had a higher rate of respiratory problems and accidental injury than the general population.

A further study by Swift, Copeland and Hall (1997) of 200 long term cannabis users from Sydney confirmed the existence of a cannabis dependence syndrome among this population. Participants in this study comprised males and females, aged in their late twenties, who had been using cannabis for an average of 11 years. Over half of the sample used cannabis daily, and three-quarters used cannabis on at fours days per week. Most of the sample used heads, and administered this with a bong, thus maximising the amount of THC delivered per usage. Almost half of the sample had experienced problems with other drugs, and one quarter had a history of problem drinking. The prevalence of cannabis dependence among this sample was comparatively much higher than their North Coast counterparts, with 92 per cent meeting DSM-III-R criteria. Again, level of dependence was correlated with cannabis consumption level. Almost all of the sample used tobacco regularly. The observation of high prevalence of respiratory illness among this sample could be due to tobacco smoking as well as cannabis smoking.

The DSM-IV criteria, used in the present manual, require at least three of nine criteria to be met in order for a diagnosis of cannabis dependence to be made. These are outlined in Table 1, below. The focus of this conception of drug dependence is on operational definitions of various aspects of habitual drug usage. The criteria for dependence explicitly represent a unidimensional construct, designed to reflect the degree to which an individual is involved with drug usage in a dependent manner. Thus, dependence is differentiated from drug harm, or "abuse," which is actually a separate DSM diagnostic category. Furthermore, the DSM diagnosis for dependence can be classified according to severity or magnitude, reflecting the fact that dependence is a continuous, rather than categorical, construct.

Criteria for Substance (Cannabis) Dependence

A maladaptive pattern of substance abuse, leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance

(b) the same (or a closely related) 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 to control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance, use the substance (e.g. chain smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance abuse

(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 or exacerbated by the substance

(* American Psychiatric Association, 1994, p. 176)

1.5 How prevalent is cannabis dependence?

In addition to recent research on cannabis dependence symptoms, there has been an accompanying focus on defining the prevalence of cannabis dependence in various communities. Population-based studies have consistently revealed that cannabis is the most widely used illicit substance in communities around the world. Estimates of the number of persons who have ever tried cannabis are typically in the order of one third (Makkai & McAllister, 1993) to one half (Anthony, Warner & Kessler, 1994). While most of those who try cannabis never repeat the experience, some users do engage in recreational use. However, the majority of those recreational users do not go on to develop a dependence. Approximately 10% of those who ever use cannabis become daily users, and approximately 20-30% use cannabis on a weekly basis (Donnelly & Hall, 1994). Available data are consistent in their support of the view that cannabis dependence is likely to develop only in those who are daily or near-daily users. The research by Swift et al. (1997) supports this idea, with the finding that most daily smokers met DSM criteria for cannabis dependence.

Epidemiological studies in the USA, New Zealand and Australia have suggested that cannabis dependence has an overall prevalence of about 4 to 5% of the general population of Western nations. Among those who have ever tried cannabis, the prevalence of cannabis dependence has been estimated at 8 - 13% (Adlaf, Ivis & Smart, 1994; Kandel et al, 1997). The proportion of regular users who display symptoms of cannabis dependence is approximately 60% (Robins & Regier, 1991).

There is also recent evidence that there have been substantial increases in the number of cannabis smokers seeking professional assistance to quit, or to manage other cannabis-related problems. The 1995 census of clients of treatment service agencies found that there had been a 60 % increase in clients seeking help for cannabis problems, compared with the previous survey in 1992 (Torres, Mattick, Chen & Baillie, 1995). Similar reports have been received from the United

States, where one agency received a strong response after publicising their new service for cannabis users (Roffman & Barnhart, 1987).

1.6 Health and psychological effects of cannabis abuse

Although cannabis has often been claimed to be a drug with little or no adverse health effects, research over the past two decades has shown that this is clearly no correct. To be sure, cannabis is a drug of extremely low acute toxicity, and death from overdose is unknown. Nevertheless, there are known risks associated with its long term, regular use, and these risks are best appraised in comparison with the two most widely abused substances in most parts of the world: alcohol and tobacco. The risks of cannabis use are neither greater nor less than alcohol or tobacco (Hall et al, 1994), which suggests that cannabis has an important influence in contributing to health and psychological morbidity and mortality.

The foremost health problems arising from long term cannabis abuse are related to the respiratory system. Like tobacco, the inhaled smoke from burnt plant material contains tar, carbon monoxide and carcinogenic substances. These have contributed to cancers of the upper airways and oral cavity, as well as diseases such as emphysema and increased risk of bronchitis and pneumonia. Women who smoke cannabis are exposed to the risk of reduced fertility, low birth weight babies and possible contribution to birth defects. There may also be an increased risk of leukaemia among babies exposed to cannabis smoke *in utero* (Hall, Solowij & Lemon, 1994).

A number of deleterious psychological effects are associated with long term cannabis abuse. These include subtle forms of cognitive impairment, including changes in short term memory and selective attentional processes. It is not clear whether these changes are reversible after the cessation of cannabis use. Some individuals appear to be at risk of development of symptoms of psychosis, particularly those with a personal or family history of schizophrenia. Finally, some individuals appear to experience profound reductions in motivation and achievement of goal-oriented tasks, including school and work performance.

1.7 Cannabis treatment research

While there have been a range of therapies applied to the treatment of drug dependence, there has been very little systematic development of interventions designed for cannabis dependence to date. Most interventions used for cannabis dependence have been adaptations of alcohol interventions (eg. Miller & Gold, 1989; Zweben & O'Connell, 1992). The 12-step fellowship movements, including Alcoholics Anonymous and Narcotics Anonymous have also been used by cannabis clients seeking assistance. Many cannabis users, however, feel that their needs are not met by such groups. The establishment of Marijuana Anonymous is still in a fledgling stage in the US and has not been established successfully in Australia. Furthermore, the efficacy of 12-step interventions remains unproven. Controlled trials of cannabis interventions have used aversion therapy (Smith, Schmeling & Knowles, 1988) and supportive expressive psychotherapy (Grenyer et al, 1997), and likewise, their efficacy has not been established.

Several randomised, controlled trials of CBT for cannabis dependence have been performed recently in the US by Roffman and Stephens and their colleagues. These studies have compared CBT with a basic skills training approach, both of which were tailored specifically to meet the unique demands of cannabis dependent clients (Stephens, Roffman & Simpson, 1993; 1994). The interventions

were delivered in a group format. Although no differences in abstinence 12 months after therapy were detected between the interventions, there were substantial reductions in number of days of cannabis use and cannabis problems, compared with pre-treatment. Overall, 20% of the sample were abstinent one year after the intervention, which is comparable to most studies of efficacy in the alcohol (Mattick & Jarvis, 1993) and tobacco smoking cessation (Mattick & Baillie, 1992) fields. The CBT approach used by Roffman and Stephens offers a promising, empirically verifiable approach to the treatment of cannabis dependence, and clearly warrants further investigation.

The current intervention represents an attempt to develop an effective intervention for cannabis dependence for the Australian context, using an individualised CBT approach.

2. INTERVENTION PROTOCOL

2.1 Format of therapy

The CBT intervention outlined here is based on a large scale, randomised controlled trial of a CBT intervention for cannabis dependence. For the purpose of evaluating this intervention empirically, it was necessary to adhere strictly to the guidelines laid down in this manual. However, individual therapists may have reason to deviate from these guidelines in order to meet individual requirement, or, indeed, to improve upon the original intervention.

This CBT program for quitting cannabis use is based upon an outpatient treatment format, with individual client therapy. Individualised treatment was regarded by the current authors as superior to a group format, as it allows the intervention to be tailored to meet the specific requirements or unique needs of each client. Although an individualised approach is used, the program has also been designed to be delivered according to a highly structured format. The general basis for the CBT program is identical for each client, but a limited choice of cognitive behavioural skills is available within certain sessions for clients to select, in consultation with their therapist, according to need. This provides the most appropriate balance between the need for a systematic intervention for evaluation purposes, and the flexibility desired for meeting individual clients' needs.

Instructions for the delivery of the CBT intervention are outlined for each of the six sessions in this manual. These instructions are intended as general guidelines, around which a therapist will be able to inject his or her own style and experience. Also included in the session-by-session guidelines are recommendations for the length of time that should be allocated to each individual component, and a list of materials (printed worksheets or handouts) that are required for each session. Copies of some of these session sheets are contained in Appendix A. *(The full set of therapy worksheets can be obtained by contacting the first author)*

2.2 Timing and length of intervention

The CBT program is designed to be performed over a total of six therapy sessions. Each structured session should be of approximately one hours length.

A single assessment session is undertaken in the week prior to therapy commencing in which key data are obtained from the client, and an outline of the nature and content of the therapy is given. The original assessment for the research trial on which this method is based required a 90 min assessment session, owing to the large number of assessment and research questionnaires administered. Individual therapists may find that the assessment time can be cut down substantially with a more streamlined interview and judicious use of assessment instruments.

Questionnaire data may be scored in the week prior to the first CBT session, to allow relevant comprehensive feedback to be provided to the client.

Ideally, the timing and physical location of the therapy sessions should be as consistent as possible. That is, appointments for the same time and day should be made for each subsequent week, and the place (ie consulting room) should be held constant. This may help to optimise the establishment of a working rapport with the therapist and assist the client in becoming comfortable with the therapeutic arrangements.

Although weekly sessions are preferable, there will be occasions when clients cannot attend or forget their appointment. In this case, an attempt should be made to reschedule for the same week, and if that is not possible, the session should be carried over to the regular time the following week. Missed sessions of more than three weeks in a row are a serious compromise to the effective running of the program, and clients in this position should be encouraged to consider seriously their reasons for being involved in the program.

2.3 Inclusion and Exclusion Criteria

Because this manual was developed for a research trial of the efficacy of the CBT intervention, strict inclusion and exclusion criteria were employed. These are outlined below. While therapists using this manual should bear in mind that the efficacy of the methods described here are based on these criteria, they should also be encouraged to make their own judgements regarding the suitability of individual clients for treatment with this intervention.

Clients should be aged 18 or over and have fluency in speaking and reading English. This is necessary for completion of research instruments and consent forms, as well as the need for a high level of communication during sessions.

Clients should meet DSM-IV criteria for cannabis abuse or dependence in the past 12 months. They should not be currently dependent on any other substance (excluding nicotine), using DSM-IV criteria. Although many clients are likely to abuse alcohol, this is not an automatic exclusion criterion. Instead, a cutoff score on the AUDIT (Alcohol Use Disorders Identification Test; Saunders & Aasland, 1987) of 15 has been determined for the present program. This score is elevated from the usual cutoff of 9 for determination of problem drinking status. Hence, clients may have mild problems with alcohol, but alcohol abuse should not be so severe as to compromise their capacity to successfully quit using cannabis.

For the purposes of the research study, it was important that clients had not received a formal intervention for cannabis dependence in the past three months, nor were currently engaged in treatment for a substance abuse problem.

Clients with major psychopathology should be excluded, although no strict criteria have been established for this issue. The main criterion is whether, in the clinical opinion of the therapist, the client is incapacitated by some form of psychopathology to the extent that it would compromise success in the current program. In this way, clients with mild levels of depression or anxiety will not be excluded, but clients suffering severe examples of these disorders would be excluded. Clients who currently qualify for a diagnosis of a DSM Axis I diagnosis may be included in the program if their symptoms are currently stable or sufficiently mild as to cause no impact on their ability to progress satisfactorily. Clients who are currently symptomatic (eg. severe depression, psychosis) should not be included.

Detoxification

Clients were accepted without the need for a full detoxification prior to the commencement of the CBT intervention. Thus, it may be appropriate to provide some advice about the role of detoxification here. The cannabis dependence syndrome does involve some symptoms of physical dependence, which may be

manifested as physical withdrawal symptoms upon cessation of cannabis use. These symptoms, while uncomfortable, are unlikely to require specialist treatment or medical assistance. Such symptoms may include sweating, insomnia, restlessness, headache, nausea and gastrointestinal disturbance. The guidelines in this manual take into account the client's likely need for detoxification. This is accommodated within the parameters of the present treatment intervention.

2.4 Assessment procedure

For the purpose of the research on which this manual is bases, a detailed assessment package was developed. It should be noted that this assessment would normally not be necessary for the purposes of most practising therapists. A guide for appropriate assessment procedures is therefore outlined here.

The assessment for the randomised, controlled trial comprised a structured, clinical interview, in which key data pertaining to demographics, drug use, family history, pattern and history of cannabis use, past treatment experiences and criminal history were obtained. In addition, clients were required to complete a number of self-administered instruments. These were mailed to the clients prior to the assessment, and were brought in for the scheduled assessment appointment.

The structured interview was adapted from that used by Swift, Copeland and Hall (1997) in their study of patterns of cannabis use among long term users in Sydney. Copies of this interview can be obtained from the first author at the National Drug and Alcohol Research Centre.

2.4.1 Psychometric instruments

For the purposes of the present program four instruments were used to diagnose cannabis dependence. For diagnosis using DSM-IV criteria, the CIDI (Composite International Diagnostic Interview) is used. Two versions of the CIDI were used: the full version (WHO, 1997) and the University of Michigan short CIDI (UM-CIDI) (Kessler et al., 1994). Diagnosis of cannabis dependence using ICD-10 criteria was obtained using the Ontario Adult Drug Use Questionnaire (Adlaf, Ivis & Smart, 1994). Finally, the Severity of Dependence Scale (SDS, Gossop et al, 1992) was adapted from assessment of heroin dependence to cannabis dependence. This scale provides an assessment of psychological aspects of cannabis dependence. Of these measures of dependence, the SDS is the briefest and most clinically useful instrument. However, while it has been well validated for use with other drugs, there are no available data on its validity for use in measuring cannabis dependence.

The instruments which were self-administered are:

- SCL-90-R (Derogatis, 1994)
- BDI: Beck Depression Inventory (Beck, 1978)
- STAI (Trait version: Spielberger, 1981)
- Cannabis Situational Confidence Questionnaire
- Cannabis Problems Questionnaire

The last two instruments in the above list were developed for the present program. These are: a scale to measure confidence in resisting cannabis use in a variety of situations or mood states (self efficacy: adapted from Sitharthan & Kavanagh, 1990), and a global measure of problems arising from cannabis use (adapted from

Williams & Drummond, 1994) These are being developed in further research to establish their psychometric properties.

Clients were required to sign an informed consent form, approved by the relevant local ethics committee (University of New South Wales Committee on Experimental Procedures Involving Human Subjects). A copy of the consent form can be found in Appendix B.

Therapists may consider a briefer assessment procedure to suit their individual purposes. They may wish to dispense with some of the lengthier procedures outlines here. Suggested minimum data would include a brief history of the client's cannabis use, quantity and frequency of cannabis use, a measure of dependence such as the Severity of Dependence Scale (SDS). The Cannabis Self Efficacy Scale and Global Problems Scale may also be of use to some therapists, especially as these can be used to monitor clinically relevant changes over time.

2.5 Classification of treatment dropouts

Clients who have failed to attend three appointment in a row are normally considered to be treatment dropouts. Therapists working on the present program found that when clients continually failed to attend appointments, there was little likelihood of them successfully completing treatment. Therapists should decide for themselves whether it is worthwhile pursuing individual clients.

Clients who fail to complete at least three of the six sessions likewise will be considered to be a dropout. Nevertheless, all clients who are assessed are included in the treatment outcome analyses of the present randomised controlled trial (ie analyses were conducted on an intention to treat basis).

3. GUIDELINES FOR DELIVERY OF COGNITIVE BEHAVIOURAL TREATMENT PROGRAMME

This section outlines the content of the CBT program, used in the randomised, controlled trial, described on a session-by-session basis. While this manual aims to provide as comprehensive a description of the method as possible, completely verbatim instructions are impractical, as individual therapists must respond to each client's requirements differently. Thus, a guideline for delivering the intervention is provided, which allows conformity with the general principles while maintaining an individualised approach by the therapist.

SESSION 1

3.1 Setting the scene & introduction to motivational enhancement training

- Profile of cannabis use worksheet
- Self-monitoring forms
- Pamphlet with health and psychological effects to stimulate discussion of pros and cons
- reminder card for next appointment

This session constitutes the first part of the treatment intervention, although the assessment completed a week earlier will mean that this is the second meeting with the client. The broad aims and outline of the treatment will have been explained briefly at intake. Therefore, a slightly more detailed depiction of the program should be provided at this point. The client may have thought of questions, or have concerns or comments which s/he would like to share at this point.

3.1.1 Ground rules & outline of treatment

The standard therapeutic guidelines should be explained to the client at the commencement of the session. These include the "rules" of the program. The major points to explain include: the need for the client to maintain a record of prompt attendance, and a requirement of 24 hours notice to change appointments. Clients should be reminded that they are expected to attend all six sessions in order for the intervention to have its optimal impact (although the consent form allows for recrimination-free dropout). There may be some advantage in setting out the grounds rules for therapy in a contract, which the therapist and client both sign at the commencement of treatment. This will ensure that both parties understand the conditions upon which the therapy is based, and record them in an unambiguous manner.

It is useful to outline the rationale of cognitive-behaviour therapy in the first

session. It should be explained so that the client understands that this CBT intervention involves the learning of specific skills or techniques that will assist the client to become effective in making desired changes and maintaining those gains in the longer term. The client should be made aware that s/he will be expected to work hard to overcome problems with cannabis and that effective gains are not achieved without some hard work, which will certainly be rewarded. Explain that this approach to treatment involves a collaborative relationship, which means that the therapist and client should work together for an optimal outcome. The advantage of a collaborative relationship also means that the client has an important role in deciding and influencing the content of the intervention. It is important that the client has a role in determining the pacing of the sessions, as well as the choice of coping skills to be developed (Sessions 4 and 5).

It should also be indicated that the general purpose of CBT involves a simultaneous emphasis on the client's *thoughts* and *actions,* and the interrelationship between these factors. Although the present program must follow a standardised format (owing to the requirement for methodological rigour), there is ample room for individualisation, and every effort should be made to make the program as relevant to the client's needs as possible.

The therapist should outline the specific elements of the program to be covered throughout the six sessions, and indicate how these will assist the client in quitting cannabis. While it will not be possible to outline every component, an attempt should be made to point out the most important ones. These might include:

- Enhancement of motivation and exploration of reasons and motives for smoking
- Urge/craving management skills
- Identification of triggers for smoking
- Learning techniques for managing automatic thoughts that accompany smoking, especially negative or irrational thinking
- Techniques for managing negative moods: eg. anxiety, stress, depression
- General coping skills: Assertiveness & communication skills, stress management & relaxation, etc.
- Relapse prevention strategies

The therapist should elicit from the client any specific areas that seem to be of particular interest or importance and make a note of these (for example, does the client have a history of poor sleep?; are they interested in relaxation exercises?; do they seem to lack social skills?).

The therapist should outline a plan for therapy for the coming six sessions, and involve the client in the decision-making process.

Suggested Time: 15 min

3.1.2 Feedback from assessment: Profile of cannabis use pattern

The therapist should share with the client any or all of the important features of the assessment. The aim here is to complete a picture for the client of his or her cannabis dependence profile, using aspects from the assessment. These can be summarised on the handout sheet "Your Cannabis Use Profile."

i) Level of dependence

The fact that the client probably qualifies for a diagnosis of dependence should elicit concern, although it is not likely to be a surprise. Discuss the implications of this, and consider the issues involved with physical and psychological dependence. This can be achieved by providing feedback on the client's level of dependence using the Severity of Dependence Scale. Use the guide for rating dependence on the handout and confirm whether the client considers this to be an accurate reflection.

ii) High risk situations and triggers

Self efficacy or situational confidence is another key construct to discuss. Review the *Cannabis Smoking Situational Confidence Scale,* and compile a list of the high risk situations or "vulnerabilities." Elicit the client's concerns about high risk situations, and discuss the circumstances surrounding these. Introduce the concept of personal triggers, then go on to explain how triggers promote thoughts about smoking, and often lead to increased desires or urges.

Help the client to make an inventory of his or her high risk situations and triggers by listing any item that is rated as less than 50% on the *Situational Confidence Scale.*

Dealing with high risk situations can be briefly introduced at this point, and returned to later in more detail. This will allow this issue to be addressed in conjunction with more detailed strategies, such as dealing with urges, cognitive skills, etc.

iii). Reasons for smoking: Pros and Cons

Discuss the client's reasons for smoking, perhaps referring to the stated reason in the assessment for commencing smoking. Consider the positive aspects, and determine how important these still are. After considering the positive aspects of smoking, turn to the negative or less good things about smoking, and begin to make a contrast between the positive and negative effects of smoking. Establish whether the positive reasons outweigh the negative.

One approach for weighing the positive and negative factors involves completing a Pros and Cons exercise outlined on the handout sheet, to obtain a decisional balance score. If the client is highly motivated to commence with his or her quit attempt, it may be sensible to move on to planning strategies for quitting. If, however, there is ambivalence or uncertainty, introduce principles of motivational interviewing.

Consider also the pros and cons of quitting, and again assist the client to appreciate the differences between these motives. These may be somewhat different to the pros and cons of smoking.

Suggested Time: 10 min

3.1.3 Motivational enhancement training

This section outlines the basic steps required for a brief motivational interview. The therapist must decide whether this component is required, as some clients may have already recently quit or are highly motivated and ready to commence a quit attempt. Such clients, who would be considered to be in the action, or late contemplation, stages of change (Prochaska & DiClemente, 1986), would have no need for a motivational enhancement intervention. This section is intended to

increase the motivation to change for clients who have some degree of ambivalence, or would be considered to be in the earlier levels of the contemplation stage of change.

The standard approach outlined by W.R. Miller and colleagues (eg. Miller & Rollnick, 1991) shall be used to enhance motivation to change. Although most clients are likely to be at least at the contemplation stage, some will have a greater desire to change than others. Attempt to establish the clients position with regard to attitude to changing, and structure motivational interview accordingly. The following guidelines might be adopted for a "difficult to budge" client. Others may require less work, and so time may be more fruitfully spent on other activities.

The critical conditions for promoting change (accurate empathy; non-possessive warmth and genuineness) will be gradually established during the course of the session. Suggested strategies for promoting motivation to change (according to Miller & Rollnick, 1991), include:

giving ADVICE
removing BARRIERS
providing CHOICE
decreasing DESIRABILITY
practising EMPATHY
providing FEEDBACK
clarifying GOALS
active HELPING

The therapist should attempt to construct a discussion around the goals of the client, and the client's motivations for seeking treatment. The client should have received clear advice in the previous section, that is, quitting smoking is important for his or her long term health and wellbeing and to avoid likely problems developing or worsening in the future.

In a collaborative discussion with the client, consider the reasons that have prompted him or her to arrive at the point of commencing treatment, and help the client to see these reasons in a global sense. Develop a decisional balance equation by eliciting from the client the pros of using cannabis and compare them with the cons. Which is the most important at this stage? This procedure can be made more vivid for the client by drawing up a list of "good things" and "less good things", or problems, associated with cannabis use. Each of the items on the list might be given a rating out of ten to determine how important they are personally to the client. This should be done without referring to the current problems that items on the cons list might be causing.

For example:

Susan's pros and cons ratings

	PROS			CONS	
1.	relaxation	= 7	**1.**	causing depression	= 9
2.	socialising	= 4	**2.**	lung infections	= 3
3.	working on sculpture	= 9	**3.**	expense	= 6

In the pros list, the client has given a rating of 9 out of 10 to the question "how important is it to you not to feel depressed (or to overcome depression)".

Now add up the totals for each side. Which is greater - the pros or the cons? The balance should tip one way or the other.

The greater total is likely to indicate which way the client is inclined for giving up. If the cons are greater than the pros, the client is probably clear about wanting to quit. However, if the pros are greater than the cons, there may still be some difficulty in deciding whether or not to quit. This ambivalence should be managed by greater perseverance with the motivational enhancement strategy. Help the client to identify any barriers to quitting and collaborate to enable these to be minimised.

Encountering ambivalence

If the client is in a genuine state of ambivalence, attempt to explore the reasons that may underlie this. Establish the initial reasons for the client seeking treatment, and reasons for using/wishing to quit. Again, guide the client through a firm and rational discussion of the issues involved. Incorporate information on health and psychological effects of continuing to use. Establish the nature of any doubts that might exist. Help the client to construct challenges to faulty logic or irrational beliefs or thoughts about the nature of the process of quitting. Encourage the client to just get on with the job and reassure him/her that quitting is never as difficult as it seems at the beginning. Positive reinforcement and encouragement will assist the client in taking the first tentative, but crucial, steps.

Suggested Time: 20-25 min

3.1.4 Setting goals

Consider the goals of the client via a discussion about reasons for smoking and reasons for wanting to quit. Although abstinence is the desired goal, controlled usage may be preferred by some. It may be necessary to have a period of abstinence before recreational use is attempted. Consider the degree of dependence, recent pattern of use, and previous attempts to control use, and discuss these issues with the client.

The experience of the therapists in the recent trial of this intervention found that few clients were able to achieve controlled use of cannabis for a sustained length of time. Restricting smoking to weekends or social occasions usually lead to slow but steady increases in smoking over time. Clients must have a firm, personal rule for recreational smoking if this is the preferred goal, eg. only to smoke when offered (that is, never to buy their own supply), and to restrict use to no more than one smoke per week.

Indicate that the nominated quit day will be set for some time in the week following the next session. Confirm that this is OK, or identify the next suitable day during the following week.

Encourage the client to start tapering their use if possible, so that cessation is not as severe when the time comes. Set a cannabis reduction regime for the following week, with the aim of reducing consumption evenly by at least 75 per cent by the quit date.

Suggested Time: 5-10 min

3.1.5 Introduction to behavioural self monitoring:
Introduce the idea of a smoking diary (e.g. by explaining that: *"These are successful with people trying to quit smoking cigarettes or to cut down on their drinking"*). Provide the client with the self-monitoring form, and explain how the form is to be filled out. Explain that keeping tabs on smoking behaviour over time has an important influence in helping to slow down the "automatic" nature of an addictive behaviour. This strategy helps clients to realise that most cannabis use is not really needed: many smokes are consumed without any thought or conscious requirement. On the self monitoring form, the client should also keep a record of urges or cravings experienced on each day. Ask the client to record urges on a 1 - 10 scale, concurrently with amount the smoked, the situation, and thoughts and feelings at the time of smoking. There is also a column on this form to record the outcome of strategies employed to avoid smoking. Explain to the client that this column will be used in the next session to record the results of specific strategies discussed in following weeks.

Suggested Time: 5 min

SESSION 2:
3.2 Planning to Quit

Urge and triggers diary homework Personal high risk situations list from Session One Coping with Urges handout sheet Managing cannabis withdrawal handout Dealing with slips and lapses sheet Drug refusal skills sheet

3.2.1 Review of the week and homework exercise
Commence the session with a review of the previous week. Have an informal discussion about general activities (*"What's been happening, etc"*), to promote and extend rapport. Also attempt to determine whether there are any important issues that have arisen or appear to be looming.

Check that the client has completed their homework, and understood the reasons for this type of approach. If they did not complete their homework, take a few moments to fill out some of the previous week's smoking and urge diary. Ensure that the client understands the importance of these exercises, and check whether motivation is appropriate. If any blocks exist at this point, they should be discussed briefly before commencing. Check the client's thoughts on process of change and strategies for achieving changes.

3.2.2 Review of personal triggers and high risk situations
Review the urge and triggers diary, and establish whether there are any behavioural patterns surrounding cannabis smoking. Most smoking will occur in a reasonably stereotypical manner, eg. in certain places, with certain people (or on their own), or at certain times of the day. Assist the client to confirm whether the personal high risk situations (HRS) identified in Session One are confirmed by the actual occurrences recorded in the diary. Are there any high risk situations that were not previously anticipated? The diary should provide a more accurate reflection of high risk situations, providing the week has been a typical smoking week. Add any new HRSs to the summary list, and re-order them in terms of priority, if the evidence from the diary suggests that the original outline is inaccurate.

Also summarise specific triggers or cues for smoking. Emphasise the role that these play in eliciting urges. Re-order these also, if the diary suggests that the original the summary was misleading.

3.2.3 Introduction to coping with urges
This section will comprise the main component of Session 2.

i) Monitoring of smoking & urges.

Review the smoking pattern for the week. Has the client been successful at meeting planned goals for tapering? Reinforce positive changes, and address minor problems if it is convenient at this point. (Problems of a larger scale will need to be addressed at a later, more appropriate time.)

Discuss the nature of the client's urges and attempt to construct a picture of high risk situations and triggers for smoking. What are the client's most difficult times? Are they the same as those indicated last week? Has the client discovered any further situations? Have some been over-rated?

Establish whether the client used any particular strategies to overcome urges. List these on the Session 2 worksheet. Did the client forget any (relevant) strategies? Re-work any strategies that the client overlooked. Remind the client that the use of these and other strategies will become easier and more automatic with practice, and thus more effective.

ii) Effective urge management strategies: Advice to give to the client

The proposed means for assisting the client with urges or craving is based upon cognitive behavioural techniques used in the alcohol, nicotine and opioid treatment fields. Educating the client on the genesis and time course of urges is an important aspect of helping the client to prepare for the task of coping with them. Instructing the client in practical techniques for coping with urges will foster acquisition of skills to cope more effectively with this aspect of cannabis cessation.

. Understanding urges: what are they?

Begin this task with an outline of the nature of cannabis urges: elicit the client's experience of urges and focus on the fact that they are the subjective element of "drug hunger." Prompt the client to recall past experiences of the way that urges build up over time and indicate that they are reinforced by the effect of the drug on reward centres of the brain. Urges are triggered by cues for drug administration (remind the client of his or her particular salient cues or triggers). Understanding urges is an important part of the process of overcoming cannabis dependence.

. Explain limited time course of urges

One suggested outline for covering this issue might be as follows:
"Urges for smoking cannabis rarely last for very long. In fact, they almost never last for longer than about 30 minutes, providing that you have decided that you are going to abstain this time. This is true for everybody, but few smokers ever give themselves the chance to prove it." Ask the client whether there have been times when s/he did not or could not have a smoke when an urge was present. Find out whether the urge did pass. Most clients will invariably have had past experiences of urges passing. This is an important strategy for clients to identify, as it can greatly improve self efficacy for overcoming or riding out urges. The main message is that urges do not have to acted upon.

iii) Urge surfing and non-reinforcement of urges

This is a common technique for assisting clients in developing a means of overcoming urges. The analogy used is that urges are like waves, and reach a peak intensity before subsiding. A suggested explanation for this phenomenon is as follows:

"Urges usually come and go in waves. Therefore, if they are feeling intense, try to distract

> yourself for a little while and you will soon notice that the worst part has subsided. Imagine the wave rising up to its peak level, and then it will pass by you, leaving you feeling more comfortable and no longer in need of a smoke. This is called urge surfing. You will feel good when the urge wave has passed and you did not have to act upon it by smoking."

Another analogy involves the reinforcement of unwanted animals - urges are the same as they are continually being reinforced by cannabis use. Resisting smoking in the presence of an urge will help to weaken the urge via the process of extinction.

> "...Each time you overcome a bout of craving, it makes the cravings weaker for next time, and makes you stronger as your technique for resisting improves. Urges can be compared with feeding a stray cat. In the beginning, you may want to feed the cat because it cries for food and attention. You may find that it is a nice thing to do and you feel good for being kind. However, your act of feeding the cat encourages it to repeat its cries and attention seeking. You find yourself giving in each time. Over a period of time the cat grows bolder and other cats join it in crying for food and attention. You may begin to regret your actions, as a large number of strays are now contributing to noise and other problems. But you cannot resist the feeling of ignoring their cries. You may believe that their survival now depends on you, and that your actions are more important than ever. They have you trapped in a cycle of your own pattern of repeated problem behaviours."
>
> "If you make a decision to resist feeding the "cat army," there will be loud and pitiful cries for a few days. In fact they will be at their strongest when you have decided not to reinforce their behaviour. Soon, however, they will come to realise that they are no longer being reinforced, and will gradually diminish and disappear. Your decision to stick with the action you know is best for you will "undo" the problem that you unknowingly built up in the first place."
>
> "Urges do go away, but they may be very strong for a short while immediately after quitting. Knowing that they will weaken will help you to continue to resist the impulses that you will feel, especially in response to your personal triggers."

iv) Urge coping strategies: distracting and delaying

Another useful strategy is to use distraction, or avoiding situations which contain strong triggers. Remind the client that to persist in sitting in front of the TV (if that is a trigger), with other people nearby who are smoking, and with other personal cues nearby, will only enhance the urge levels.

Distracting works on the principle that urges are thoughts, and thoughts can be changed. The easiest way to change thoughts is to change the behaviour or action that is occurring at the time. Hence, by engaging in some task that is unrelated to smoking, such as light housework, or taking a short walk, or phoning a friend, the client's thoughts will be removed from smoking to the current task. This will help to pass the short time during which the urge is active.

An associated task is to use the strategy of delaying. If bothered by an urge or craving, ask the client to make a note of the present time. The next step is to make a personal commitment not to smoke for at least one hour. During this time, ask the client to engage in distraction. The key requirement of this task is to make a decision after one hour has passed, whether smoking is still necessary. In almost all cases, the client will find that smoking is no longer as important as it was earlier. An adage that the client might use in this case is to "Stop, Ask yourself, then Decide".

v) Decatastrophising

Decatastrophising refers to the tendency that most clients have of becoming overwhelmed by the presence of an urge. Remind the client that urges are not

intolerable or unbearable, just temporarily uncomfortable. One suggested approach may be as follows:

> "Also, remember that urges are just temporary feelings of discomfort. Think about the feelings that you are having and become aware of any uncomfortable sensations or feelings of tension in your body. Think about how they compare to other uncomfortable feelings, such as a bad case of sunburn or severe anxiety or grief. They are rarely as bad as they might seem to be at first. Keep in mind that while they are uncomfortable, they are never unbearable. This is called "decatastrophising" - in other words do not let them get out of proportion."

3.2.4 Planning to quit

If not already abstinent, the client should be prepared to quit smoking from this session onwards, or from a nominated day of this week.

Therefore, plan for quitting and maintaining abstinence from this session forwards, OR: negotiate for setting a quit date for one day in the forthcoming week.

The client may be uncertain about the method by which he or she should quit: cold turkey or tapering. Suitability of sudden or gradual cessation may depend largely on the client's degree of dependence. If the degree of dependence is moderate-to-severe, suggest cutting down over a few days. This might mean gradually delaying the time of the first smoke each day by 4 - 6 hours. Get the client to count the number of cones or joints and reduce this by about 20 per cent per day. However, if the client has been unable to slow down his or her smoking in the past year, he or she may need to quit "cold turkey."

If the level of dependence is mild-to-moderate, the client may be better suited to quitting "cold turkey." This method helps people to get on with the task and may simplify it by eliminating complicated daily or weekly goals for reducing. Urges may be intense at first, but will rapidly diminish with each additional day of abstinence.

If the client has used one method successfully in the past, encourage its use again now. However, if one method has been difficult or resulted in failure, suggest the other method this time. Try to enhance the client's optimism in approaching the task by highlighting previous success, or, alternatively, a new approach to a difficult, but not impossible, task.

3.2.5 Information and discussion of withdrawal symptoms.

If the client has a high level of cannabis dependence, it may be useful to spend a brief period of time discussing cannabis withdrawal symptoms. Again, education about the nature of the symptoms, and instruction in techniques to manage them successfully is needed.

i) Nature of cannabis withdrawal

Most clients will likely have experienced some degree of cannabis withdrawal symptoms in the past. Therefore, they will be reasonably well informed about what to expect. It may be important not to over-emphasise the difficulty of cannabis withdrawal - like other drugs, some may have little or no discomfort upon cessation. Clients will be aware that cannabis does not produce severe physical withdrawal symptoms like those of alcohol or heroin. Usually, the psychological or subjective symptoms are the most prominent. However, there may be some

physical symptoms, and understanding what they are and how to deal with them will help. Indicate that not everyone experiences withdrawal symptoms, and most have only mild-moderate effects. These symptoms are uncomfortable, but are not dangerous (if necessary, explain that it is not life threatening, and cannot result in any physical harm).

The main symptoms of cannabis withdrawal involve feelings of anxiety, restlessness, trouble concentrating, depression, irritability and anger, and urges to smoke. Most clients report a kind of nervous, restless energy. Some experience dramatic mood swings, especially toward irritability or anger, and may find themself over-reacting to otherwise trivial situations.

Physical symptoms may include insomnia, tremors, feelings of restlessness, night sweats and loss of appetite. Some clients also experience an upset stomach, together with nausea and occasionally diarrhoea. Again, reassure the client that these symptoms are just temporary and will soon pass. Some over the counter medication to ease the gastrointestinal symptoms may help significantly. Remind the client that any symptoms of withdrawal are signs that their body is recovering from the long term effects of cannabis smoking, so they can be viewed in a positive light. Withdrawal symptoms are unmistakable signs that they are on the path to recovery!

3.2.6 Examine social support systems

One important factor in a successful attempt at overcoming a drug problem is access to effective social support. The therapist should by now have a reasonable sense of the nature of the client's social support system. The most appropriate persons from whom support can be obtained include family members or close friends who are understanding and sympathetic to the client's own goals. Research from the alcohol and tobacco treatment literatures suggest that social support improves outcome significantly.

Indicate that the client will benefit from some assistance from someone close. Ask the client to nominate one or more people from whom support might be obtained. Briefly discuss what role that person can play, and when they are most likely to be of most assistance.

The client should understand the meaning of "support," especially the fact that others cannot do the task for the client. Similarly, family and friends should not attempt to control the client or force behavioural change. The client may need to educate his or her social supporters in ways that they can be most productive: encouraging and assisting within the parameters of the clients own goals, rather than coercive or domineering.

In summary, identify with the client:

WHO might be able to support you? Consider which people have in the past been:

- Usually supportive
- Usually neutral (friends or relations who don't know about your problems)
- Usually hindering (they may become more supportive with some effort on your part)

WHAT types of support will be most helpful?

- Help with problem solving
- Moral support
- Someone to share the load
- Information and resources
- Emergency help

HOW can you get the support or help you need?

- Ask for what you need. Be specific and direct.
- Add new supporters (people who can help you with your current problems).
- Lend your support to others; it helps you strengthen your own skills.
- Be an active listener when giving or receiving support.
- Give feedback about what was or wasn't helpful; thank the person for his/her support.

3.2.7 Dealing with slips or lapses

Finally, give the client some indication that slips and lapses are common in the recovery process. While they are disappointing and may cause some discouragement, they do not mean failure or indicate an inability to change. Explain that slips are a natural part of the process of change. The client's challenge is to find ways to quickly overcome the slip and maintain the goals as best as possible. Every slip is a learning experience, and should help the client to strengthen his or her recovery.

Ask the client to prepare a plan to implement should a slip occur. This may involve identification of the triggers or situation in which the slip occurred, the strategies that could have been used to overcome the slip, and the consequences of having a smoke. The client should also discuss it with a friend or family member, if appropriate, and make a new commitment to continuing his or her planned program of abstinence.

3.2.8 OPTIONAL SECTION: Drug refusal skills

Some clients may benefit from brief advice in drug refusal skills. In short, these involve making a simple, but confident statement to smoking companions that he or she has made a change and is no longer a smoker. Remind the client to be confident and clear in making this statement. Encourage the use of strong body language, to look the person offering in the eye and clearly say "no thanks". Also remind the client not to fall into the trap of saying "I am trying to quit" or "I am giving up". The key to drug refusal is to state "I have GIVEN up", or "I no longer smoke". Also reassure clients that friends and smoking companions will respect this decision and will be interested in the client's progress. They will usually be supportive. The client should be clear that the decision not to smoke is just what it means: it is not an indication that he or she no longer wishes to be friends with former smoking companions.

Spend a few minutes role playing drug refusal. Try to get the client to sound as natural as possible, while maintaining strict dedication to the task.

3.2.9 CONCLUDING: Goals and Homework

Summarise goals for the coming week. Ask the client to maintain the urge diary. Give the client urge coping exercises to complete. Ask the client to approach a family member of friend for support. Plan a strategy for dealing with slips or

lapses: an emergency drill. Finally, for those who require it, ask the client to rehearse drug refusal skills.

SESSION 3
3.3 Managing Withdrawal and Cognitive Restructuring

Urge monitoring form (also monitor thoughts & feelings) Awareness of Negative Thinking sheet Managing Negative Thinking sheet Common Thinking Errors handout Strategies for Challenging Negative Thoughts handout

3.3.1 Review of the previous week.

As with previous sessions, commence with a general discussion about the week and consider any issues that may have arisen. The client's main task will have been to achieve abstinence, so this is the first issue that should be discussed. Naturally, reinforce success. Clients who have not maintained abstinence will probably be disappointed. However, a review of the weekly smoking record will probably reveal substantial signs of progress. (Only the seriously ambivalent or non-committed will be no better off at this point). Help the client to see how the week has been a positive step, and help them to outline what has been achieved. Attempt to maintain the client's motivation by emphasising positive elements of the week's progress. Be clear in giving advice that the final goal, of overcoming cannabis dependence, is still achievable despite setbacks or failure at this point to meet every goal.

Move on to positive activities, beginning with a review of the urge diary. Establish the nature of the problem situations, and elicit the client's concerns or feelings about those problem areas. Provide feedback and encouragement for goals that have been met. Where goals have not been met, there will need to be some discussion about how to remedy the situation.

If appropriate, also review high risk situations and triggers, and redefine the client's strategies for dealing with those situations. Establish whether the client feels confident in handling those situations. If there is difficulty with particular situations, see whether the client can avoid those situations altogether for the next few weeks. If that is not possible (eg. a particular time of day, or being at home with noisy children), emphasise being prepared for the feelings (eg. tension, urges to smoke) that these triggers will elicit. This will help the client to overcome "automatic" responding to the trigger by smoking. Remind the client that these are situations where urge management strategies will come in useful. Review the strategies of distracting and delaying, and decatastrophising. The third "D" will be covered in the present session: *D*isputing expectancies.

Finally explain that the program will include assistance in acquiring better coping techniques: eg. managing stress, managing anger, assertiveness skills, building social support, and a relaxation exercise.

Suggested time: 5 - 20 min.

3.3.2 Reviewing withdrawal symptoms:

Ascertain from the client the nature of the withdrawal symptoms that have been experienced over the previous week. Review the withdrawal diary to determine the worst symptoms. Ask the client how difficult he or she found it to cope with the worst rated symptoms. These may include insomnia, restlessness and boredom, irritability, sudden unprovoked anger, tremors and sweating.

Begin the discussion by reframing these symptoms in a positive light. Remind the client that the withdrawal symptoms are actually signs that the body is recovering and readapting to being cannabis free. Also emphasises that the symptoms are short term ones only - it is impossible for these symptoms to persist for a very long time. Tell the client that most of the symptoms will gradually resolve within the next 7 to 10 days. Some clients seem to tell themselves that unpleasant withdrawal symptoms are simply what life is like without cannabis, which makes their decision to remain cannabis free a rather short lived one!

The most difficult withdrawal symptoms should be amenable to behavioural management. In particular, insomnia should be manageable by adopting standard behavioural strategies for improving sleep quality. Sleep disorders will be covered in a separate section below.

General advice should include instruction in understanding the nature of the withdrawal response. Indicate that withdrawal reactions are often the opposite physical response to that of cannabis. Therefore, when cannabis causes an increase in appetite, withdrawal may result in a decrease or loss of appetite. The same applies for psychological symptoms: instead of feeling more relaxed, withdrawal may result in feeling less relaxed and more tense.

As with management of urges, recommend the strategies of distracting and delaying, and decatastrophising. Most of the uncomfortable withdrawal symptoms will come and go, just as urges to smoke do. Encourage the client to become aware of any feelings of discomfort and tension in the body at the time of feeling discomfort. Get the client to take a few deep breaths and relax as much as possible. Tell the client to remind him- or herself that the symptoms will soon pass and that it is not unbearable.

Suggested time: 5 to 10 min.

3.3.3 Cognitive restructuring: Cognitive issues in quitting cannabis

This section is the main focus of Session Three, and will therefore occupy the majority of the time available for the session. Of course, a detailed grounding in cognitive aspects of drug use could easily occupy six or more full therapy sessions. This component of the programme does not aim to undertake formal cognitive therapy. The main purpose of this component is to introduce the client to the major cognitive issues in cannabis cessation, and to begin to develop appropriate cognitive strategies for coping with problematic thoughts.

Although this introductory session is brief, there will be time to return to these issues in Sessions 4, 5 and 6, if required. This will ensure that the main elements of the cognitive strategies that are to be employed will be fully utilised by the client. The main aim of cognitive restructuring is to assist the client to determine when he

or she is thinking negatively or engaging in automatic patterns of thought that lead to drug use. The techniques employed should assist the client to interrupt this style of (automatic) thinking. Finally, the client should learn to challenge negative thoughts and to replace them with more positive ones, or thoughts that help to reduce the urge for using cannabis.

i) Outline for introducing Cognitive Restructuring

Begin this component with a brief discussion on the issue of "automatic thoughts." The client should be familiar with the concept, and will probably respond readily to the notion of recurring unwanted thoughts about wanting to use cannabis. One theme that appears common is the process of mental "justification" for smoking, despite having decided previously not to smoke. Clients state that these justifying thoughts tend to be automatic and persist without any real effort being made to create them. The feeling is of the mind "playing tricks," and can be distressing owing to their persistence and capacity to undermine sincere efforts to abstain.

Also introduce the client to the notion of self talk ("the voice inside your head"), and elicit examples of both negative and positive patterns of self talk.

Next move on to the key concept of cognitive restructuring: that thinking influences the way a person feels and the way they behave. In other words, **T**houghts lead to **F**eelings and **A**ctions. It is important for the client to understand that emotions and the response to those emotions (eg. smoking cannabis to overcome stress or anger) are not the direct result of some external influence. This, of course, immediately appears to be counter intuitive, as the client may want to suggest that an insulting gesture or the death of a loved one will **cause** feelings of anger or sadness.

Indicate how one's **thoughts** always come before any feelings or actions. A person's thoughts usually arise **automatically** in response to a particular event, and so therefore, we tend not to be aware of them. The thoughts that we have in response to particular events is usually the same each time. They are very predictable in this sense. Automatic thoughts cause us to **interpret** events in a certain way, which may lead to negative feelings.

The diagram below (also on a handout sheet: see Appendix A) explains this process, using Ellis's "ABC" model:

A ----------->B ----------> C
Antecedent event Belief Consequences

Provide an example of this model. For example:

Somebody insults or criticises you ----------> "I'm hopeless / stupid" ------> Depression, tension, anger

Assist the client to generate another example.

Indicate how the usual interpretation is to exclude the "B" step, that is the belief or

automatic thought. Most people assume that "A" causes "C". Explain how this is not true. There may be some resistance to this idea, and clever clients may enjoy providing examples that falsify the model. Some discussion of this issue may be important for the client to become convinced of its validity. The important point to convey is that our thoughts are what give rise to our feelings, and that most thoughts are automatically generated. **Point out that these thoughts can be changed,** and this can have the effect of helping a person to deal more effectively with adverse circumstances.

ii) Changing automatic thoughts: Delaying action

The next step is to help the client to understand that negative thoughts can be changed by "catching" them, or becoming aware of them before they are acted upon. Encourage the client to react to a negative thought in the same way as they do with urges: STOP, SLOW DOWN and THINK ABOUT the thought. Make a decision not to act upon the thought for a short period of time, and the chance is that the thought will soon pass without any harmful consequence.

iii) Changing automatic thoughts: Challenging and replacing negative thoughts

Negative thinking can be changed by becoming aware of the thought (see above), and then by directly challenging the thought. Help the client to find ways to challenge the major negative thoughts that he or she tends to experience. The basic steps to help in this process might include:

1. Examine the evidence
2. Consider what is wrong with thinking that way
3. Decide whether the thought is unhelpful (a thinking error)
4. What alternatives are there for this thought?

It will be useful, if time permits, to generate several examples of challenging negative thinking, so that the client has fully understood the basic process involved.

iv) Application to drug use

The ideas discussed above are general, and might be more easily explained in a general sense rather than in reference to drug use. Therefore, it may be necessary to relate the model to drug use *per se.* This can be done in two ways: In general people are more able to deal with problems when they are less troubled by negative thinking. Explain the role of negative thoughts in the genesis of depression, anxiety, and other negative states. Indicate how correcting and overcoming negative thinking will help in the *overall* process of overcoming dependence on cannabis.

The second suggestion is that much negative thinking is closely linked to cannabis use. That is, cannabis use is often a consequence (STEP C) of a negative thought. The client should be able to start challenging negative thoughts that lead to drug use (eg. I feel stressed, the only way to cope is to get stoned).

v) Discussion of the role of expectancies

This component might be ended with a brief introduction to the role of expectancies in drug use. Explain how much anticipation of having a smoke (and the concomitant urges/desire) is due to the influence of expectancies. These may be positive (a smoke will put me in a good mood and make me more sociable), or negative (smoking will get rid of my stress or boredom).

Like negative thoughts, expectancies can be challenged. Most clients would be very surprised to learn that the main effect of smoking small amounts of cannabis is due to psychological expectancies, rather than the physical effect of the drug. That is not necessarily to say that smoking a placebo would induce the same effect, but that the major positive benefits of smoking cannabis are mediated by the client's expectation of feeling a certain way, based upon past experience.

This may be met by some with incredulity. One way of approaching this scepticism might be to inquire about any time in the past when the client was desiring a smoke to overcome some negative affective state, but had no cannabis available. Ask the client to consider the feelings (positive expectancies) that he or she may have had at that point. Then ask them to remember how they felt when cannabis suddenly became available (eg. obtained money to score; they finally found a dealer, etc). The client will typically have experienced an improvement in mood at this time. According to the logic of most smokers, this change in mood state should only be achievable by actually smoking cannabis, yet there is marked improvement with the knowledge that it will be available. Ask the client to consider this as an example of expectancies mediating the urge or desire to smoke, and in the same way, mediating the perceived positive effects of smoking.

In general, high expectancies and low confidence in resisting leads to strong urges. Encourage the client to challenge automatic expectancies, by replacing them with alternatives: eg. "I need to smoke to relax," replaced by "smoking may relax me, but I know that giving myself permission to spend time on my own and unwind for a while will also help me to feel the same effect."

Suggested time: 40 min

3.3.4 Ending the session

Help the client to focus on the goals for the coming week: these should be continuing abstinence for most. Those that have failed to attain abstinence in the past week should be encouraged to try again this week. In the worst cases, look at the possibility of smoking a limited quantity on certain days, or at certain times (e.g. before trying to sleep, only).

Homework exercises should include: continuing to monitor urges, introduce monitoring of negative thoughts, and recording responses to them.

SESSION 4:
3.4 Review of Cognitive Strategies and Skills Enhancement

Urge monitoring form SIDS handout Problem Solving sheet, or Sleeping Better sheet, or Relaxation sheet

3.4.1 Review of previous week

Again, begin with a review of progress, discussion of problems, and recap on any previous techniques misunderstood or not working

Pay particular attention to the "negative thoughts" diary from the previous week. Establish whether the client has incorporated these ideas by checking the sort of challenges to negative thinking that the client has come up with. Discuss this also in a "real life" sense, so that the client can actually use this technique when it is needed.

It may be useful to spend a brief period of time going over the main points from the previous week, and tying these strategies in with any problems that the client has had during the week.

The discussion of automatic thoughts and expectancies should then lead conveniently into an introduction to seemingly irrelevant decisions. This should require about 10 min to discuss.

3.4.2 Seemingly Irrelevant Decisions (SIDS)

Many aspects of any drug use can become repeated so often that it becomes very automatic. Getting and smoking cannabis seems to happen without any effort or conscious decision making. In fact it often seems to be harder to avoid smoking than it is to actually smoke. While this phenomenon seems like an impossible issue to overcome, it is not difficult if you know what to do.

Many episodes of cannabis use actually begin long before the client actually lights a smoke. There are lots of small steps in the chain of events that leads to having a smoke. Some of the obvious ones are getting out the stash, mulling up, packing a cone or rolling a joint. But there are lots of little steps that lead up even to this point. They may be things like making time to prepare for having a session, sitting down in a certain room, being in the company of certain others. In many instances, the chain of events starts hours before you actually have a smoke. Unconsciously and often without thinking about it, many people make seemingly irrelevant decisions that take them along a path which concludes with them ending up in a high risk situation and then smoking.

Ask the client to think about whether they have ever attempted to avoid smoking, only to find that their best intentions came undone and they wound up in a situation where it was impossible to resist. It may have been temptations from

other people. On the other hand, they may have unintentionally exposed themself to internal triggers, such as boredom or stress, which set off a sequence of events that led to smoking.

Being aware of the impact of seemingly irrelevant decisions on the probability of having a smoke is important. Trying to minimise temptations well before they grow into high risk situations will help the client to maintain their goals.

Ask the client to list any SIDS that they know they have made in the past. Try to think up a few likely SIDS that they could imagine themself making in the future.

Give the information and homework sheet to the client and point out the main aspects of this exercise.

3.4.3 Development of Personal Skills

The main issue to be covered in Session 4 is the development of skills for maintaining abstinence. The skills appropriate to each client will probably differ according to the individual's need. Therefore, select from the following according to immediate relevance:

- Coping skills training/ problem solving techniques
- Cognitive Behavioural therapy for sleep disorders (including assessment of problem, education, reviewing sleep hygiene)
- Relaxation training (progressive muscle relaxation). Review of uses and planning for rehearsal (Jacobsen, 1974; Walker, 1975).

It is expected that instruction in only one of these techniques will be possible in the time available. In particular, instruction in progressive muscle relaxation will require around 30 min. The other skills may require less time, although this will depend upon the degree to which the client "takes" to the relevant skill.

i) Problem solving skills

The aim of problem solving training is to enable the client to resolve real life problems that impinge upon his or her ability to maintain a drug free lifestyle. Acquisition of problem solving skills should assist the client to cope with difficult situations, without depending upon drug use. Furthermore, effective problem solving strategies should help the client to lead a life with less stress overall, thus lessening the automatic thoughts for smoking and reducing the perceived need for cannabis.

The main goals of this training are to help the client to:

- Recognise problems, or types of problems, more effectively
- Become skilled at generating effective solutions
- Select the best strategy for the problem at hand
- Execute the strategy and evaluate its effectiveness afterward

Begin with an explanation of the need to become good at solving problems. Outline the idea that problems are a recurring part of everyday life, and our ability to deal with difficult issues makes a big difference in how we generally feel. Not

handling problems or issues as they arise can lead to feelings of stress, anger and depression. Explain the we sometimes start to avoid certain things, which can place us under more pressure later on. Elaborate this idea with the client, and attempt to get the client to join in with actual examples. Indicate that while everyone is different in their ability to solve problems, it can be learned and improved just like any other skill. The advantage of this is that the client can then use that skill anytime it is needed in the future. This has a big impact in helping people to lead easier lives, and reduces the pressure which often leads to drug use. In addition, it can also help to provide ways to deal with situations that previously would have resulted in drug use.

Outline the fundamental steps involved in problem solving. These essentially involve breaking the problem down into manageable steps, ie:

1. Defining exactly what the problem is
2. Generating ("brainstorming") possible solutions
3. Selecting the most appropriate approach
4. Devising a detailed plan for attack
5. Executing the plan
6. Reviewing the outcome

Each of these points should be dealt with briefly, relying on actual examples to demonstrate the point. Allow the client to come up with his or her own ideas or solutions for each of the six steps. To enable this to be done realistically, get the client to volunteer some actual problems that he or she has faced recently. It may be very reinforcing for the client to have a take-home solution to a difficult problem.

Ensure that the problems considered are reasonably precise. Very large or general issues should be broken down into manageable chunks. This approach should also be emphasised to the client, as huge issues are almost always impossible to handle without analysis of the smaller issues involved.

The client should be quickly able to learn the fundamental ideas involved in this approach to problem solving. Going over a variety of actual examples is the best way to help the client to learn the basics of this skill. Emphasise that the instructions given in the session will be quite useless without actually going out and consciously practising the technique (an analogy such as "like learning to drive a car by reading a book about driving" might be employed).

Provide the client with the instruction sheet and homework exercise, and outline the homework to be completed for the coming week.

A useful guide to teaching problem-solving skills is provided in Monti et al. (1989) and Chaney (1989).

ii) Management of Insomnia

Many clients will probably have had some difficulty with insomnia. Some brief advice and development of strategies for its management should produce good results.

Begin this component by ascertaining the nature of the sleeping problem: is the

insomnia sleep onset, sleep maintenance or early morning wakening? These may reflect different problems, and may indicate different approaches in their management.

Sleep onset insomnia is likely to be the most common insomnia due to cannabis cessation. It is likely to be a rebound effect arising from withdrawal. Educating the client in sleep hygiene is an important first step. Review with the client the issues surrounding the bedtime ritual (or lack of), the sleeping environment, and the sleeping patter (time of going to bed, latency to sleep, length of sleep, behaviour if unable to sleep, etc). In general the client should receive advice to promote good sleep.

a) Firstly, check that the client is not exposed to noise, light, or other disturbance (e.g. a restless or snoring sleeping partner). Rearranging the bed or the bedroom may help to reduce external disturbances.

b) Outline principles of good sleep hygiene. Encourage the client to go to bed at the same time each night. This helps to train the internal clock to expect to sleep at the same time. Establish a ritual before bedtime, such as having a cup of herbal tea or decaffeinated coffee), visiting the bathroom and making sure the house is properly locked up. Such activities, if practised habitually, are important cues for preparing to sleep. Explain that watching TV or other activities in bed (other than quiet reading or sexual activities) tend to result in the bed being associated with wakefulness, rather than sleep.

c) Stimulus control treatment of sleeping problems can help to re-establish a normal pattern. Remind the client that most people require 10-20 min to fall asleep. They might be used to falling asleep as soon as they go to bed, owing to the effects of cannabis. Suggest that any delay in getting to sleep is simply a return to a more normal pattern (further evidence of overcoming cannabis dependence!). If the client is unable to sleep, advise getting out of bed and going to another room until ready to sleep. This may take anywhere from 15 min to a few hours. Above all, it is important to avoid getting anxious and uptight in bed as this only worsens insomnia for the following night, and may establish a pattern of stress onset when the client should be experiencing sleep onset.

d) Generate suggestions for activities for times when the client is unable to sleep. A warm bath helps to relax (bath salts and oils might also be beneficial), drinking warm milk helps to boost tryptophan levels. Some natural remedies include herbal teas such as chamomile or passionflower, valerian preparations (tablets or tea), and the aroma of lavender oil. More "heavy duty" preparations include over the counter medications such as antihistamine compounds or other, non-addictive sleep-inducing medications.

Encourage the client to resist the urge to sleep in or to nap during the day: this also delays re-establishing a sound sleeping pattern.

These principles will assist also with sleep maintenance insomnia. The key is to avoid getting anxious and upset: this only delays sleep. Some individuals go to bed tired, but become anxious when in bed owing to sudden, intrusive thoughts about the possibility of not being able to sleep.

Early morning wakening is unlikely to be a result of cannabis withdrawal. While this may be indicative of depression, it may also reflect the fact that the client does not need the "nominal" eight hours of sleep. Unless the client is tired during the day, arising early may not be a problem. This is more frequent among older individuals. Suggest going to bed later, or finding some useful, enjoyable activity to due in the early morning hours.

Finally, learning an appropriate relaxation technique (see below) is usually invaluable in assisting a client to obtain natural sleep. This needs to be practised and good results will be obtained over time. Ensure also that there is no evidence for more serious causes of sleep disorder, such as sleep apnoea, dream anxiety or night terrors, or somnambulism. If the problem is particularly intractable, get the client to maintain a sleep diary (not another one!), and explore patterns in the sleeping cycle.

iii) Progressive Muscle Relaxation

This technique is the widely used procedure described by Jacobsen (1974). The advantage is that it avoids requiring the client to slow down mental activity, which is very difficult for most people to do consciously. Instead, the emphasis is on gradually relaxing the skeletal muscles. This short circuits a feedback loop, in which muscle tension informs mental tension and stress, which in turn results in physical or muscle tension. Feeling physically relaxed tends to slow down mental activity and induce a peaceful feeling. While there are considerable differences between individuals in their ability to relax effectively, almost any client will find the technique useful to some degree. Also, like the other skills of this programme, practice and development of the technique will see substantial improvement.

Begin by having the client seated (not lying down) in a comfortable chair, feet flat, and arms by their side or in their lap. Offer a few preliminary words, such as outlining what you will be doing. It is important that the client understands what this is NOT: ie. hypnosis, or an altered state of consciousness. The client will be in control at all times, and will not be asleep or unable to respond in any way. The feeling will be like the relaxed state experienced just before going to sleep or just after wakening.

Explain that you simply want the client to listen to what you are saying, but not to **try** to do anything. Trying hard to relax does not work. You will make some suggestions and the client will simply listen to those and gradually feel him or herself becoming more and more relaxed. Mention that the client's thoughts may wander, and this is natural and OK. Simply ask the client to return his thoughts to what you are saying whenever he realises that his thoughts have wandered.

Ensure that the delivery is even, quiet (although not too quiet), and in a gentle, reassuring tone. Sudden changes in tone can break concentration and spoil the effect. An outline for delivery is provided in Jacobsen (1974; also see Appendix A for handout sheets). However, as an overview, the session will require the therapist to ask the client to consider the tension in different muscles of the body slowly being released or melting away. Start at the top of the head, and move through the forehead and eyebrows; cheeks, lips, tongue and jaw; neck and shoulders; arms, elbows, forearms; wrists hands, fingers; chest and stomach; thighs, knees, calves ankles, feet and toes. By the time the toes have been done

the client should be completely relaxed. Some like to ask the client to tense various muscles, in order to feel the difference between tension and relaxation. Employ this technique if the client appears to be having trouble relaxing effectively.

At the conclusion of this exercise, discuss its applications. The situations in which the technique can be used should be briefly explored. The obvious one is as a general relaxation strategy. This can be used also to assist sleep onset. The technique should be encouraged when the client is feeling upset, anxious or stressed. However, many clients will never think to use this technique when they are in such a state. Therefore, encourage its use in a modified way, such that the client might use elements to maintain calm and keep tension under control. This might involve doing a "mini-session" of 5 min later or so, during which time the client focuses on any existing physical tension, and consciously attempts to reduce this. This can be attempted nearly anywhere and at anytime, and may serve to keep stress under control, rather than letting it build to a point where few natural techniques will be effective.

Give the handout sheets to the client, and encourage practise. Ask the client to make a time for practise during the week, and fill out the record sheets. Again, emphasise the importance of practise for proper effectiveness of the technique.

SESSION 5:
3.5 Reviewing and consolidating. Introduction to new skills if required

List of materials needed for Session 5:

Assertiveness skills handout and homework sheet Communications skills handout and homework sheet Managing anger handout and homework sheet Monitoring urges and withdrawal diary form

This session is designed to allow a detailed review and consolidation of the previous sessions. The pace of the first four sessions is quite fast, and therefore some clients may need a chance review over certain aspects of the programme again. This session allows the opportunity for that, and the fine tuning of personal techniques for those who are coping successfully at this point.

3.5.1 Review of previous week
Begin the session with a review of the client's overall progress. Have there been any slips or lapses. Ascertain whether there are any specific issues or problems. If these can be addressed within the framework of any of the strategies outlined previously, then it would be appropriate at this point to return to that strategy and approach it with the specific problem in mind.

Alternatively, the client may wish to review a strategy for its potential usefulness. This also would indicate a return to the relevant strategy, and reviewing it in the light of the client's recent experience.

3.5.2 Coping skills training
The therapist must use his or her discretion at this point to determine whether the

client has important deficits in the development of the range of strategies. If particular attention to one strategy or another is warranted, then a review should be undertaken.

If consolidation of the initial techniques can be completed with 15 min or more to spare, it would be recommended that one of the following skills is introduced:

- Assertiveness skills
- Communication skills
- Anger management

Guidelines for the delivery of each of these skills will be outlined below.

i) Assertiveness skills

Begin with the idea that every person has a personal set of rights: eg. to be respected, to be heard, to express feelings and opinions. Also, individuals have the right to make mistakes, to say no without feeling guilty and to change their mind. Having these rights are important for every person to express themselves, to be understood by others, and to have their personal needs met.
The aim of assertiveness training is to develop ways of expressing him- or herself, in a rational, appropriate manner that ensures the maintenance of one's individual rights and the respect of others. One important feature of self assertiveness

The following points should be explained in relation to acquiring assertiveness skills:

- 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.

ii) Communication skills

General points to be covered:

Conversations

These pointers should make it easier for you to start a conversation.

- It's OK to:
  - Start with simple topics.
  - Talk about yourself.

- Remember to:
  - Listen and observe.
  - Speak up.
  - Use open-ended questions to prompt a response.
  - Check your reception.
  - End the conversation gracefully.

Nonverbal Communication

"Body language" can be very useful in helping you to get your point across.

- Posture
- Eye contact
- Facial expression
- Tone of voice
- Head nods
- Hand movements and gestures
- Personal space

iii) Stress/anger management

Dealing with anger, like management of most negative affective states, can be effectively achieved using the principles of cognitive restructuring. The most convenient way to assist the client with anger management at this point is to refer back to the cognitive restructuring exercise employed in session 3. The relationship between negative thoughts and anger is a direct one, and feelings of anger, irritation or frustration can be effectively managed by modifying the cognitive processes that underlie these feelings. Management of anger may be a particularly important strategy for many clients, because as a negative mood state, anger has the potential to prompt relapse if there is no better coping mechanism.

Begin the outline of the technique by discussing the nature of anger to the client. For example: *"Anger is a normal human emotion. Increased awareness of angry feelings will make it possible for you to cope with them so that they don't get out of hand. Increase your awareness of the following:"*

General issues to be covered:

* Events that trigger anger:
  - Direct attack on you
  - Inability to reach a goal
  - Unfair treatment
  - Seeing an attack on someone else
  - Excessive demands on you

* Internal reactions that signal anger:
  - Feelings: frustration, annoyance, irritation, feeling on edge or wound up
  - Physical reactions: muscle tension, headache, sweating, rapid breathing
  - Difficulty falling asleep
  - Depression or feelings of helplessness

Encourage the client to identify specific triggers for anger, and work through an example of restructuring the relevant cognitions to focus on more positive thoughts. Also remind clients that relaxation exercises are very important as the feeling of anger commences. Try to help the client to become more aware of the feeling of onset of anger as a "signal to cope", ie. to employ cognitive restructuring and a relaxation procedure. Remind the client that this takes some effort at first, but becomes easier and more automatic with each successful attempt to manage.

Each of these skills should take at least 20 min. There will probably not be time to introduce each one to the client, so select according to need.

3.5.3 Concluding the session

Outline the homework task for the coming week. These will include the activities relevant to the new skills introduced in the present session. Also remind the client about maintaining the urge and withdrawal monitoring diary.

Also check whether the client feels comfortable about nearing the end of the program. Inquire about whether there are any issues that the client would like particularly to cover in the next (last) session. If these are issues that have already been introduced, it will be reasonable to spend up to 10 min going over them in Session Six. If other issues are brought up, consider options for referring on, especially if those issues relate to wider psychological problems.

SESSION 6:
3.6 Relapse Prevention and Lifestyle Modification

List of materials needed for Session 6:

Self monitoring forms
List for pros and cons of smoking
List for effective strategies for avoiding slips (from earlier sessions)

The primary reference for this session is the widely cited text by Marlatt and Gordon (1985). The purpose of Session 6 is to introduce the client to the main ideas of relapse prevention, and to prepare the client for maintaining abstinence for the future.

3.6.1 Overview of previous week's homework
Check homework sheets and ensure that the client has at least made a start at developing the new skills. Discuss likely applications and highlight the best possible uses of these skills. Establish whether the client feels confident in continuing to use these skills, and arrange for the client to continue with their use over the next few weeks (ie. identify specific instances where the skills might be used, or make time for practice, either alone or with others).

3.6.2 Relapse prevention: main ideas to be covered
Begin this component by exploring with the client his or her plans for the future, and discuss the role that smoking cannabis may or may not have in the achievement or maintenance of these goals. These goals may involve a variety of themes. Review the reasons for quitting that the client gave in the first session. It can be very useful at this point to look over the pros and cons worksheet completed in Session 1. Usually, after a few weeks of abstinence, the perceived pros of drug use no longer have any relevance. Realising this will help the client to

become even more dedicated to maintaining abstinence for the future.

It may also be useful to spend a short time working with the client on the identification of any continuing or recurring problems, and attempting to find practical ways of resolving such issues. This may be a good time to help the client to employ problem solving skills, or to identify a specific coping strategy that will help to overcome the problem. Spend a short time supervising the client in his or her attempt to outline a plan for action.

i) Beware of rationalisations

Rationalisations are an important means by which clients become vulnerable to relapse. These arise often through negative, irrational thought processes. Like seemingly irrelevant decisions, rationalisations are the result of old, automatic thought processes which the client must become aware of in order to manage them effectively.

To assist the client with this important potential relapse precipitant, it is suggested that the means by which rationalisations can occur is explained. This may involve a discussion about how the going can seem tough in the first few weeks after therapy, and some people feel that their mind "plays tricks" when thinking about having a smoke. Sometimes these thoughts even make it appear that it would be OK to have a smoke. Such rationalisations seem to automatically make excuses for having a smoke. The main strategy is to prompt the client to remain aware that rationalising is a type of negative thinking, and as such, is a real threat. Remind the client to treat such thoughts as warning signals, which require a coping strategy. Using strategies for challenging negative thinking is important here.

A role play exercise where the client is prompted to recall previous rationalisations might be a useful way to plan and rehearse such strategies. As well as looking at ways of challenging negative thinking, prompt the client to make a firm, positive statement to himself, affirming the decision to quit and the desire to be successful. This will help to short circuit the strange twists that one's mind can make when starting out on the road to long term abstinence.

ii) Separation loss or anxiety

Many people giving up drugs say that they feel like they are losing a good friend. Discuss this issue with the client. Elicit his or her feelings about the role of cannabis as a comforting, familiar activity, and explore ways in which cannabis can be replaced. Helping the client to rediscover warm, close interpersonal activities like hugging one's partner or close friend is an important way to replace perceived feelings of comfort that cannabis may have provided. Even a pet can provide some positive response that can be very reassuring. It is important that the client gives such gestures, as well as receive them.

Also discuss wit the client ways in which these feelings can be countered, again through challenging excessively negative thoughts and focusing on thinking positively about the present or the future. Such feelings do pass, although they take time. People who have been successful in quitting cannabis feel invigorated as they begin to discover new possibilities and opportunities as their period of abstinence from drug use increases.

iii) Reviewing your progress

A major relapse prevention technique is to ensure that the client remains vigilant in the future, particularly during the first few weeks after completing therapy. This can be effectively achieved by having clients record their progress. An important strategy for maintaining long term abstinence is to have a pre-prepared emergency drill for managing a slip or lapse. While this topic has been covered in brief in an earlier session, more time and detail can be spent here by developing a point-by-point plan for managing a slip.

By this stage, the client will have found that some strategies are more useful or relevant than others. Spend some time discussing those strategies that are most useful and emphasise their importance to the client. Positive reinforcement of this type will play an important role in continuing to build self efficacy. Also consider strategies that the client has not used, and determine in consultation, why these are not utilised. The client may need to be reminded of their relevance or given more assistance in making them effective. Because they may not have been effective the first time, does not mean that they are not going to serve a useful role in the future. Emphasise the need to have as complete a set of available strategies as possible, and remind the client of the need to be adaptable.

Assist the client in developing a system for monitoring slips or lapses. Suggest that any slips, or even near-slips, should be recorded, and a particular strategy identified to overcome such problems in the future, This will help to encourage the client that such slips are not insurmountable, and provides a practical way of learning to break old, automatic patterns. If done regularly, this may help the client to see the early warning signs of impending slips, and allow the client to know as soon as possible what action needs to be taken.

For example:

Problem:

Remedy
Practise urge surfing and delaying

Plan ahead and anticipate SIDS

Review coping with high risk situations

iv) Dealing with lapses

It is quit common for people to make mistakes when they are trying to learn any new task or skill. Becoming free of cannabis dependence is no different to learning any other skill. And just like any other skill, people do stumble occasionally. It is important to know that this does not mean failure, but is a temporary setback. Many people who are ultimately successful find that they have a slip along the way.

What is important in long term success is how the client handles that slip. Different ways of dealing with slips depends on the type of slip. One such type of slip is lapsing "on purpose."

Lapsing on purpose:

Lapsing on purpose can happen for a couple of reasons. One may be that the client ensures him or herself that it is too much effort. They may get tired of working at their plan, and decide to take a night off. Alternatively, the client may decide that they deserve a reward for the hard work, and smoking is naturally their favourite way of rewarding themself. These feelings certainly happen to a lot of people.

If the client has lapsed purposely for these reasons, they should think carefully about their reasons for wanting to quit. Focus on the original reasons for deciding to quit and encourage the client to decide how much these reasons still mean to him or her. Remind the client that each slip will lessen their chances of long term success. They will result in urges returning more strongly again, which means more hard work. It may be a case of *"buy now, pay later."* Clients inevitably kick themselves when they realise that the urge that lead to the slip would have gone away in a short time anyway.

If a client has had a slip because of exposure to high risk or tempting situations, that is, despite best intentions, help him to examine his overall quit strategies. What can be improved? Was there a SID made along the way? Is the client finding some high risk situations to hard right now? How can he deal with it more effectively? Doing some homework in this way will definitely help the client to achieve his goals more effectively.

Remember, the best thing is to get back on track as soon as possible, and remain

positive about the overall effort to be successful.

v) Personal rewards

Often, people feel that they deserve a reward for all the hard work, and the best reward is, of course, a smoke. Ensure that the client remains vigilant to this pitfall. Help the client to have other rewards already worked out in advance, and encourage him or her to be honest in giving themself a deserved pat on the back after achieving the goals they have set.

One approach may involve explaining the following idea:

> "At the end of each successful week, you should give yourself a pat on the back for a job well done. Even if you have not been perfect, you should think of the good things that you have achieved and be proud of them. If there have been mistakes or problems, remain positive by examining what they are. At this point you owe it to yourself to make a list of the things that have not been successful, and summarise them. Think of strategies that you can use to help you to avoid making the same mistake again."

vi) Self monitoring

Encouraging the client to continue self monitoring of urges and strategies employed to manage urges and negative thinking is also an important way to remain vigilant against relapse. Self monitoring will help clients to make sure that they are keeping track of their commitment to stay clean, and can assist in recognising patterns in coping that may be problematic.

The best way to do this is to continue to keep making regular entries in the self monitoring sheet. If the client has had trouble attaining the goals that have been set for the week, they can review the strategies that are being used and make appropriate changes to maintain forward progress.

vii) Relapse prevention: enjoying drug-free activities

After former smokers have been abstinent for a while, they often start to discover new aspects to life that weren't possible while smoking heavily. This is a reward in itself. Discuss with the client ways in which he or she will feel better physically and have more energy and enthusiasm for life. However, remind clients that things are what they make of them, and they will find that the effort that is put into quitting smoking at first can later be channelled into developing other aspects of life that the client would like to change or enhance.

Make a list with the client of things that he or she would like to change or enhance and discuss briefly the role that smoking cannabis has in attaining those goals. Of course a serious client will see no role for cannabis in their new lifestyle, and this point, together with a formal list of desired goals or aspirations, will further reinforce this fact.

viii) Dealing with urges after being abstinent

Many people find that the temptation to have a smoke may pop up every now and again, months, and sometimes years after quitting. This is often a fleeting feeling, and is usually easy to deal with. Remind the client that having such feelings does not mean that they have failed - it may be a natural response to certain potent triggers.

Many ex-smokers feel a curiosity after some months to have a cone or joint to see how they like it. One smoke will never undo several months of progress. However,

having even one smoke, especially within 6 months of quitting may greatly reduce a client's chances of long term success. Ensure that the client understands this issue, and devise a strategy for thinking through the issues involved in making such a slip. For example, the client can consider whether the hard work that has been achieved is worth risking for the price of a minor urge to smoke.

3.6.4 Looking to the future

Toward the end of the session, it will be important to help the client to consider the role of cannabis cessation within the client's whole lifestyle and how it fits with his or her personal aims and ambitions. Consider such simple issues as positive lifestyle and focus on health and well being. Ask the client to reflect on his or her efforts towards balancing diet, exercise, personal fulfilment and recreational activities. Review with the client the sort of non-drug activities that she or he is developing or currently enjoys and reinforce the positive effect that such lifestyle changes will have in the future.

Quitting cannabis use is no easy task, but neither is it impossible. In fact, most people say that it was not as hard as they first thought. It takes dedication, effort and persistence. If you have the desire to change, and work toward your goal in a careful and strategic way, it will work for you.

Becoming free of cannabis dependence may be reward in itself, but to many that is just the beginning. The opportunities that freedom from cannabis brings may include the reward of the lifestyle that you have dreamed about and certainly owe yourself.

If the client has had trouble in developing positive lifestyle changes, spend some time in identifying positive, pleasurable activities that the client might become more involved in. Begin by querying previous positive activities, even if these were performed in the client's childhood. Artistic pursuits, either active or passive (watching movies, enjoying theatre, galleries, etc) are one such example. Sports are also an important positive pursuit that most clients can follow with much enjoyment.

3.6.5 After the therapy has ended

It is important that the client understands that the termination of therapy does not mean that he or she is without further assistance, if required. Some clients may benefit by obtaining additional therapy immediately after the conclusion of this program, to address specific problems that have had a bearing on the client's drug use. These may include further assistance with mood/ affective disorders, counselling for early childhood experiences such as sexual or emotional abuse, or relationship counselling. Some clients may benefit from a support group, and may appreciate being put in touch with others who have recently quit smoking cannabis.

If an onward referral is indicated, try to arrange this before the client leaves the final session.

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5. APPENDICES

APPENDIX A: **SESSION HANDOUT AND REMINDER SHEETS**
PAGES 49- 73

(Forms Adapted from NDARC Alcohol Treatment Program: A, Baillie & R.P. Mattick, 1992)

Common Thinking Errors & Strategies for Challenging Negative Thinking: from T.J. Jarvis, J. Tebbutt & R.P. Mattick (1995) *Treatment Approaches for Alcohol and Drug Dependence.* Chichester: John Wiley & Sons

APPENDIX B: **CONSENT FORM**
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