

Brief COUNSELING *for* MARIJUANA DEPENDENCE

A Manual for Treating Adults



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A Manual for Treating Adults

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

1 Choke Cherry Road

Rockville, MD 20857

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SECTION I.

INTRODUCTION

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

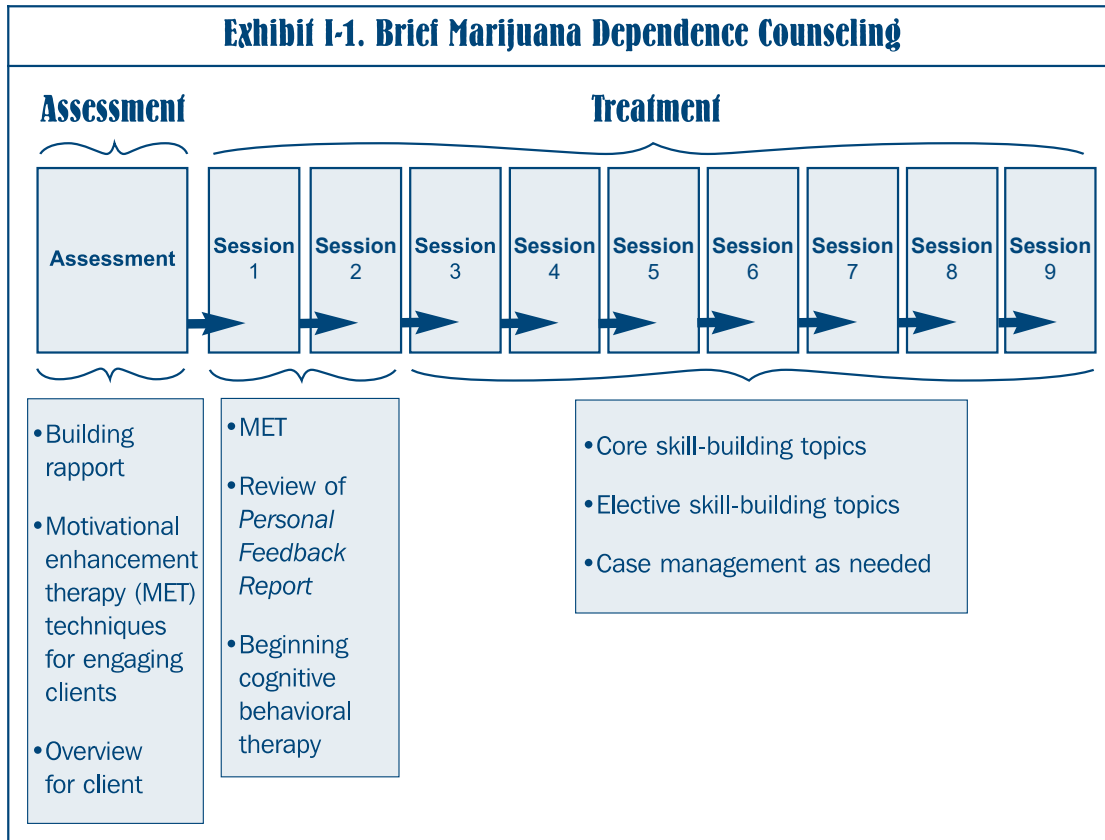
This manual for Brief Marijuana Dependence Counseling (BMDC) is based on the research protocol used by counselors in MTP. The manual provides guidelines for counselors, social workers, and psychologists in both public and private settings who treat adults dependent on marijuana. The 10 weekly one-on-one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

Me? Hooked on Pot?

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

People who become clients in BMDC may have

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



Case Examples

Doug

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

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

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

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

Shirley

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

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

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

Miguel

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

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

Brief Marijuana Dependence Counseling

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

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

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

Background

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

Current Findings About Marijuana Use

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

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

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

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

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

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

Overview of the Marijuana Treatment Project¹

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Who Should Use This Manual?

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

All BMDC counselors should meet the following criteria:

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

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

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

Organization of This Manual

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

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

Section III. Common Treatment Issues

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

Section IV. Getting Started: Assessment Session

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

Section V. Enhancing Motivation: Sessions 1 and 2

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

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

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

Exhibit I-2. Core and Elective Skill Topics in Brief Marijuana Dependence Counseling

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

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

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

Section VII. Supplemental Readings*A. Who Needs Treatment? The Nature, Prevalence, and Consequences of Marijuana Dependence*

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

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

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

C. Implementing Brief Marijuana Dependence Counseling

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

SECTION II.

OVERVIEW OF THE BRIEF MARIJUANA DEPENDENCE COUNSELING MODEL AND MANUAL

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

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

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

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

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

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

General Theoretical Assumptions

Clinical Engagement and Therapeutic Alliance

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

Meeting Clients “Where They Are”

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

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

Supporting Client Efficacy and Pointing Out Discrepancies

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

Learning About Marijuana Use Patterns

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

BMDC Therapeutic Tasks

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

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

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

Target Population

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

Structure of BMDC and the Individual Sessions

BMDC comprises nine sessions that are organized into three sections:

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

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

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

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

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

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

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

How To Use the Manual

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

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

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

SECTION III.

COMMON TREATMENT ISSUES

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

Client–Counselor Relationship

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

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

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

Orienting the Client and Confidentiality

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

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

Preventing Attrition

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

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

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

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

Recognizing Change Readiness

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

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

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

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

Ambivalence

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

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

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

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

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

Treatment Dissatisfaction

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

Compliance Enhancement Procedures

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

Didactic Material

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

Practice Exercises

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

Termination

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

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

Strategies for Addressing Common Clinical Problems

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

Counselor's Response to Missed Session

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

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

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

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

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

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

Counselor’s Response to Slips

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

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

Goal of Abstinence From Marijuana

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

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

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

Handling Marijuana Use or Intoxication

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

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

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

Marijuana Withdrawal

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

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

Use of Alcohol

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

Clients With Special Needs

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

Arranging for Additional or Followup Treatment

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

Summary

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

SECTION IV.

GETTING STARTED: ASSESSMENT SESSION

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

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

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

Building Rapport

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

Assessing Marijuana Use

BMDC uses the criteria identified in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) (American Psychiatric Association 1994), to diagnose marijuana dependence (exhibit IV-1) and marijuana abuse (exhibit IV-2). These criteria help the counselor determine a client's level of substance involvement and the associated consequences, as well as appropriate level of treatment. These criteria also can be used in later sessions to measure treatment effectiveness.

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

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