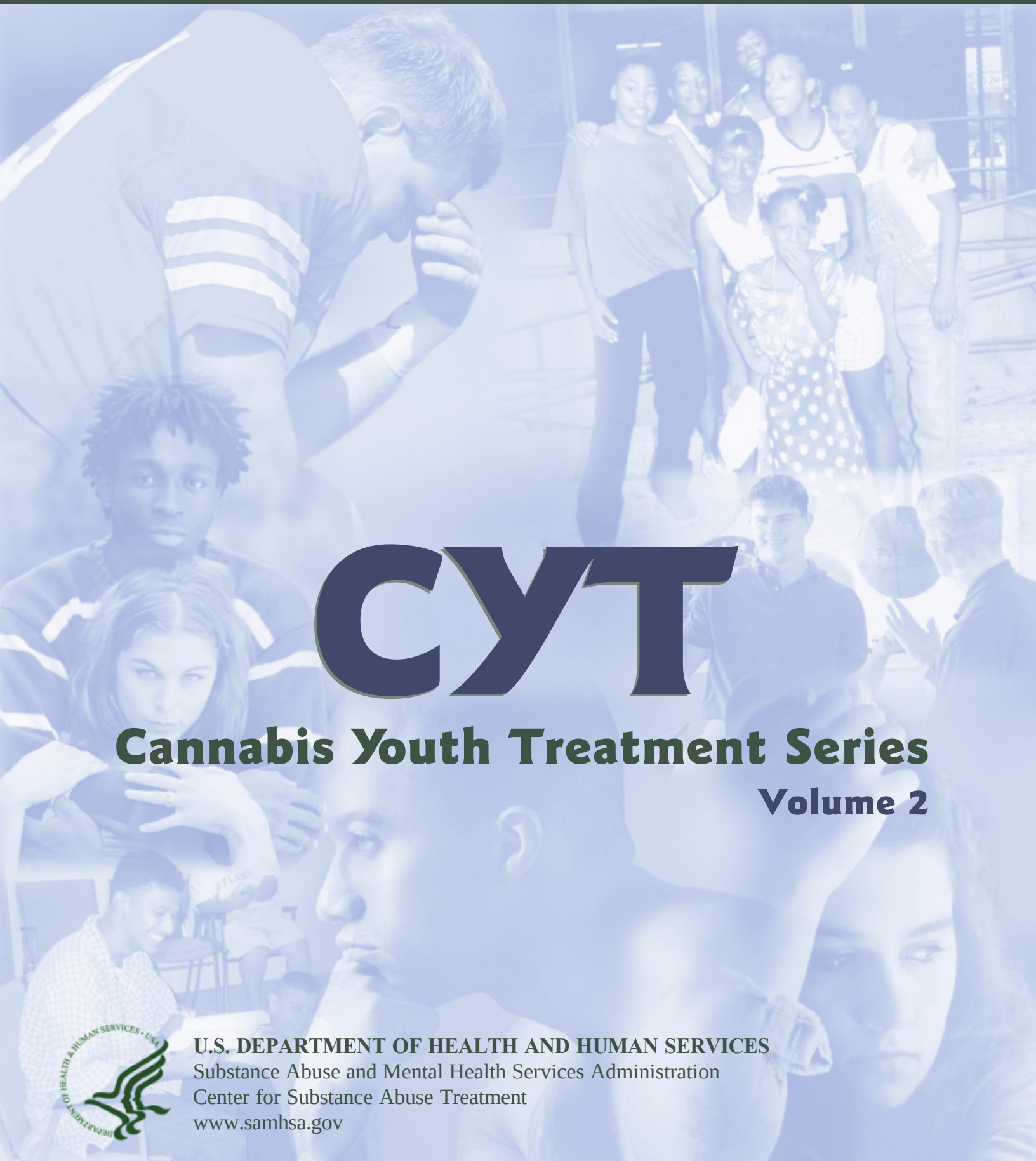
The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users



CYT

Cannabis Youth Treatment Series

Volume 2

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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This is volume two of a series of treatment manuals produced under the Cannabis Youth Treatment (CYT) Project Cooperative Agreement. The document was written by the following staff members of the University of Connecticut School of Medicine: Charles Webb, Ph.D.; Meleney Scudder, Psy.D.; Yifrah Kaminer, M.D.; and Ron Kadden, Ph.D. Field reviews and editorial assistance in producing the manual were provided by staff from Johnson, Bassin & Shaw, Inc. (Lynne McArthur, Holly Brooks, Barbara Fink, Nancy Hegle, Wendy Caron, and Tonya Young). The authors also acknowledge input and assistance received from the Executive Steering Committee (Thomas Babor, Michael Dennis, Guy Diamond, Jean Donaldson, Susan H. Godley, and Frank Tims) and many others including Nancy Fidler, Patty Gaupp, Nancy Hamilton, Julia Hemphill, Jim Herrell, Stephen Kane, Mary McCain, Lydia Robbins, Melissa Sienna, Zeena Tawfik, Joan Unsicker, and William White.

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This work builds directly on three earlier manuals developed to serve adults who have alcohol and marijuana problems: *Treating Alcohol Dependence: A Coping Skills Training Guide* by Monti et al. (1989); *Cognitive-Behavioral Coping Skills Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence* by Kadden et al. (1992); and *Marijuana Treatment Project: Clinical Manual* by Steinberg et al. (unpublished 1997). Materials appearing on page 12 (exhibit 1) and selected materials in the sessions section were adapted from copyrighted sources. Copyright and source information for the sessions begin on page 101. All the materials are reproduced herein with the permission of the copyright holders. Before reprinting, readers are advised to secure permission of the copyright holders.

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I. Introduction and Background

Introduction and Organization of the Manual

This manual, a supplement to *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions, Cannabis Youth Treatment (CYT) Series, Volume 1*, presents a seven-session cognitive behavioral treatment (CBT7) approach designed especially for adolescent cannabis users. It addresses the implementation and evaluation of cognitive behavioral treatment for adolescent marijuana users as part of the Cannabis Youth Treatment Project: A Cooperative Agreement for Evaluating the Efficacy of Five Treatments for Adolescents With Self-Reported Marijuana Use and Problems Associated With Its Use.

This volume provides instructions for sessions 6 through 12 of the cognitive behavioral therapy (CBT) for adolescent marijuana users. The first five sessions (two motivational enhancement therapy [MET] sessions and three CBT sessions) are described in *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions, CYT Series, Volume 1*.

Research provides convincing evidence of the efficacy of using cognitive behavioral techniques to help adult substance abusers (Stephens, Roffman & Simpson, 1994; Bien, Miller & Tonigan, 1993). However, relatively little has been done to test the effectiveness of cognitive behavioral techniques with adolescent substance abusers. This manual was developed to apply the cognitive behavioral approach to treat a specific type of substance abuser: the adolescent cannabis user. It provides a structured cognitive behavioral model that can be reliably delivered, monitored, and evaluated.

The three incremental arms of the CYT treatment design (Dennis et al., 1998) are MET/CBT5, consisting of 5 sessions; the MET/CBT5 supplement (CBT7), consisting of an additional 7 sessions; and the family support network (FSN), consisting of 10 sessions (6 parent education sessions and 4 home visits). In the CYT study, these three modular components were linked together in various combinations to produce interventions of varying length and scope. First, MET/CBT5 served as a stand-alone, brief intervention. Then, CBT7 was combined with MET/CBT5 to produce MET/CBT5 + CBT7. Finally, FSN was added to MET/CBT5 + CBT7 to produce a combined intervention that includes individual sessions, adolescent group sessions, parent education groups, and therapeutic home visits. Two additional treatment interventions were also studied: the adolescent community reinforcement approach (ACRA) and multidimensional family therapy (MDFT).

This manual has been adapted for general treatment use. It is divided into seven sections including appendixes. The first two sections provide background, an overview of the theoretical model underlying the design of CBT7, and discussions on supplemental issues. Sections III through VI provide an overview of session components, step-by-step procedures for implementing the treatment protocol, a glossary of terms, and the references. The appendixes

include sample posters, sample forms, and a detailed account of the CYT study. The manual is equipped with tab pages to facilitate finding individual sections.

Client and Provider Information

Target Population

MET/CBT5 + CBT7 is designed for the treatment of adolescents between ages 12 and 18 who are exhibiting problems related to marijuana use, as indicated by one of the following:

- Meeting criteria for cannabis abuse or dependence
- Experiencing problems (including emotional, physical, legal, social, or academic problems) associated with marijuana use
- Evidencing frequent (weekly or more often) marijuana use, over a 3-month period.

Although this treatment includes suggestions for addressing both drug and alcohol use, it was not originally designed for treating adolescents with polysubstance dependence or those who use other substances on a weekly basis. Adolescents were excluded from the study if they drank alcohol on 45 or more of the previous 90 days or if they used another drug on 13 or more of the previous 90 days.

This treatment was effectively implemented with adolescents with mixed demographic characteristics such as race, age, socioeconomic status (SES), and gender, as well as from different regions. MET/CBT5 + CBT7 therapists need to be culturally aware of and sensitive to the client group to whom they provide this treatment so they can provide relevant examples and use language that is understood by the clients in therapy sessions.

Likely referral sources of the clients include parents, the justice system, school personnel, and medical or mental health providers. Self-referral is rare.

Contraindications for MET/CBT5 + CBT7 are the following:

- The need for a higher level of care than outpatient treatment
- Social anxiety disorder so severe that participation in group therapy is not viable
- Severe conduct disorder
- Other acute psychological disorders of sufficient severity that they prohibit full participation in treatment.

Level of Care

MET/CBT5 + CBT7 is appropriate for use as either an outpatient treatment (American Society of Addiction Medicine [ASAM] Level 1) or an early intervention (ASAM Level 0.5).

Staffing Recommendations

The staffing level recommended for implementing MET/CBT5 + CBT7 is one therapist for six adolescents in a treatment group. In the first weeks of the treatment, the therapist sees each group participant for two individual therapy sessions. During the next 10 weeks, the therapist conducts one group therapy session per week. Additional clinician time may be needed to deal with emergencies that may occur, to address pragmatic issues such as scheduling and communication problems, and to make referrals.

Additional staff members may be required to conduct and score the initial assessments and to prepare personalized feedback reports (PFRs). An additional staff person should be available in reasonable proximity to the group therapy room when group sessions are in progress. This staff person (who may be doing other work) could assist in dealing with emergencies or supervising a client who has been asked to leave a group session because he or she is under the influence of drugs or being disruptive.

Types of Organizations

MET/CBT5 + CBT7 is appropriate for use in several types of organizations that provide outpatient care, including substance abuse treatment programs, mental health clinics, youth social service agencies, and private practice mental health and substance abuse treatment settings. Community centers, schools, or general medical settings may also be appropriate for implementing MET/CBT5 + CBT7, provided properly trained staff members are available. These latter settings may be particularly well suited for implementing MET/CBT5 + CBT7 as an early intervention.

Staffing and Certification Requirements

The CYT study used therapists who were trained at the master's degree level; however, a similar level of training is not necessary for individuals in the field.

Requirements for therapists administering CBT7 in combination with MET/CBT5 and FSN are (1) a bachelor of arts or master of arts degree, (2) certification in addiction counseling, (3) a minimum of 1 year of prior clinical experience working with adolescents, and (4) previous clinical experience with behavioral interventions.

Supervisors should have expertise in the core intervention: MET/CBT5 + CBT7. Certification criteria and procedures are detailed in appendix 3.

Scope and Significance of the Cannabis Problem

Marijuana remains the most widely used and most readily available illicit psychoactive substance in the United States, with nearly 76 million individuals reporting use at least once during their lifetime (Substance Abuse and Mental Health Services Administration, 2001*a*). Marijuana use among adolescents ages 12 to 18 continues to be a serious problem. According to results of the Monitoring the Future Survey (Institute for Social Research, 1997), use of marijuana among 10th and 12th graders continues to rise and is at an all-time high, with steady, but decelerating, increases in lifetime, yearly, monthly, and daily usages. For the first time since 1991, when data collection began on 8th graders, marijuana use among 8th graders did not increase, although rates of usage remain alarmingly high. Lifetime use (at least once during one's life) in 1997 was 22.6, 42.3, and 49.6 percent among 8th, 10th, and 12th graders, respectively, while annual use prevalence (use in the past year) was reported as 17.7, 34.8, and 38.5 percent. From 1992 to 1997, past month usage among high school seniors rose from 11.9 to 23.7 percent; among 10th grade students, monthly use increased from 8.1 to 20.5 percent; among 8th graders, it rose from 3.7 to 10.2 percent. Of particular concern is the continuing rise in daily marijuana use. Among 10th and 12th graders, the 1997 survey results showed daily use prevalence at 3.7 and 5.8 percent, respectively. Similar trends in marijuana usage have been observed in regional surveys of junior and senior high school students (Godley et al., 1996*b*; Hartwell et al., 1996). The continued increase in marijuana use has been attributed to two factors: declines both in the disapproval of marijuana use and in the perceived dangers of marijuana (Johnson, Hoffman & Gerstein, 1996).

Despite the perception that marijuana is not dangerous, the rate of emergency department mentions of marijuana more than tripled among adolescents ages 12 to 17 between 1993 and 2000 (Substance Abuse and Mental Health Services Administration, 2001*b*). Conversely, in the 12 to 17 age group, marijuana now accounts for more than twice the number of hospital emergency room cases as cocaine and heroin combined.

Minority youth represent a particularly vulnerable segment of the population because of their disenfranchised status (Dryfoos, 1990). Minority students are relatively less likely to start using illegal drugs, but among those who have done so, the proportions who use marijuana regularly are higher than among nonminorities (Kandel & Davies, 1996).

An additional danger associated with marijuana use observed in adolescents is a sequential pattern of involvement in legal then illegal drugs (Kandel, 1982). That is, marijuana is frequently a stepping stone from cigarette and alcohol use to use of harder drugs (e.g., cocaine, heroin) (Kandel & Faust, 1975). This stagelike progression of substance use, known as the gateway phenomenon, is common among youth from all socioeconomic and racial backgrounds (Kandel & Yamaguchi, 1993). In sum, adolescent marijuana use is closely linked to future drug involvement. That is, as long as marijuana use is only experimental, it portends a decline in use of all drugs later.

However, more serious use of marijuana often snowballs to involvement with increasingly addictive and potent drugs.

Whatever the pattern of marijuana use, its physical effects include fluctuations in blood pressure, decreased salivation, mild unsteadiness, impaired coordination, hunger, drowsiness, slowed speech, respiratory difficulties (Cohen, 1979; Hall, 1995; National Institute on Drug Abuse, 1986), a decrease in the immune response, suppression of testosterone production in males (Cohen, 1979), and a decrease in respiratory vital capacity.

Adolescents abstaining after chronic marijuana use showed evidence of short-term memory impairment, loss of abstract and logical thinking, inability to focus attention and filter out irrelevant information, inability to resolve normal emotional conflicts, mental confusion, and memory problems (Millsaps, Azrin & Mittenberg, 1994; Lundqvist, 1995; Solowij, 1995; Solowij et al., 1995). Studies suggest that it may take 6 to 12 weeks for even partial recovery of cognitive functioning to occur and that this process is prolonged when there is any interim use.

A commonly noted effect of chronic marijuana use is amotivational syndrome. This syndrome is characterized by apathy, decreased attention span, poor judgment, diminished capacity to carry out long-term plans, social withdrawal, and a preoccupation with acquiring marijuana (Cohen, 1980, 1981; Schwartz, 1987). Amotivational syndrome is attributed to heavy cannabis use and has been observed in adolescents (Schwartz, 1987). However, Musty and Kaback (1995) reported that amotivational symptoms in heavy marijuana users between ages 19 and 21 might actually be due to co-occurring depression. Whether amotivational syndrome is a primary or secondary diagnosis in subpopulations of marijuana abusers has not yet been resolved.

Marijuana use has also been associated with a wide variety of social-psychological problems. Rob and colleagues (1990) compared adolescent marijuana users and nonusers on a number of psychosocial factors. Marijuana use was associated with poorer family relationships, poorer school performance, and higher levels of school absenteeism. Other illegal drug use was almost entirely restricted to marijuana users, and marijuana users were more than three times as likely as nonusers to be sexually active, to drink alcohol three or more times per week, and to smoke cigarettes. Serious marijuana use is associated with a multitude of behavioral, developmental, and family problems (Kleinman et al., 1988), including conduct disorder, crime and delinquency, school failure, unwanted pregnancy, and escalating drug involvement (Donovan & Jessor, 1985; Farrell, Danish & Howard, 1992; Hawkins, Catalano & Miller, 1992; Jessor & Jessor, 1977).

Background on Cannabis Youth Treatment Cooperative Agreement Goals

The purpose of the Cannabis Youth Treatment Project Cooperative Agreement with the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) was to (1) test the relative effectiveness and cost-effectiveness of a variety of interventions

targeted at reducing or eliminating marijuana use and associated problems in adolescents and (2) provide validated models of these interventions to the treatment field. The target population was adolescents with the cannabis use disorders of abuse or dependence as defined by the American Psychiatric Association (1994). Appendix 4 includes additional information on the CYT study.

Overview of the Study

The CYT study was conducted in collaboration with staff from organizations in five different sites across the country: Chestnut Health Systems–Coordinating Center (CHS–CC) in Bloomington, IL, and Chestnut Health Systems (CHS–MC) in Madison County, IL; University of Connecticut Health Center (UCHC) in Farmington, CT; Operation PAR in St. Petersburg, FL; and Children's Hospital of Philadelphia (CHOP) in Philadelphia, PA. The study involved five treatment conditions: motivational enhancement therapy/cognitive behavioral therapy: 5 sessions (MET/CBT5); motivational enhancement therapy/cognitive behavioral therapy: 12 sessions (MET/CBT5 + CBT7); motivational enhancement therapy/cognitive behavioral therapy: 12 sessions plus family support network (MET/CBT5 + CBT7 + FSN); ACRA; and MDFT.

These five treatments were grouped in several ways. First, they varied by mode—the first three combined individual and group interventions, whereas the last two consisted of individual sessions. Second, they varied by modality—the MET/CBT and ACRA interventions were based on behavioral treatment approaches, whereas the FSN and MDFT interventions were based on family treatment approaches. Third, they were expected to vary by resource intensity and cost.

The following descriptions provide greater detail about the individual components of the CYT Project.

MET/CBT5: The primary goals of this treatment are to enhance participants' motivation to change their marijuana use and to develop basic skills needed to achieve abstinence or gain control over marijuana use. The first and second sessions are held individually with each participant. They are spent enhancing motivation and identifying high-risk situations that may increase the likelihood of relapse. The therapist explores the participant's reasons for seeking treatment, prior treatment attempts, goals, self-efficacy, readiness for treatment, and problems associated with marijuana use. A PFR is used to compare the participant's marijuana use and related problems with national norms. The three subsequent CBT sessions are provided in a group therapy format. Therapists conduct one group therapy session per week, and the group size is limited to six participants. Participants learn basic skills for refusing offers of marijuana, establishing a social network supporting recovery, developing a plan for engaging in pleasant activities that fill free time formerly occupied with marijuana-related activities, coping with unanticipated high-risk situations, problem solving, and recovering from a relapse, should one occur.

CBT7: The goals of this treatment are to enhance participants' motivation to change cannabis use, as above. However, this intervention supplements MET/CBT5 with additional training in the use of coping skills for dealing with events and personal states that, by past association, have become functional cues or reinforcers for cannabis use. CBT7 offers weekly group sessions that teach coping as an alternative to using cannabis when responding to interpersonal problems, negative affect, and psychological dependence. In these groups, participants learn problem solving, anger awareness, anger management, communication skills, resistance to craving, depression management, and management of thoughts about marijuana. Group size is limited to six participants.

FSN: This treatment uses an intensive, family-focused approach designed to improve parenting skills and to increase family cohesion, closeness, and parental support. Presumably, improving these skills increases the likelihood of both initial and sustained change. The intervention consists of case management (to promote parent engagement in the treatment process), six parent education group meetings (to improve parent knowledge and skills relevant to adolescent problems and family functioning), four therapeutic home visits, and referral to self-help support groups. At least one parent or caregiver is required to attend group meetings. All family members living at home are invited to participate in home visits.

ACRA: This treatment is composed of 12 individual sessions with the adolescent and/or the adolescent's concerned other. ACRA focuses on teaching alternative skills to cope with problems and meet needs, with an emphasis on the adolescent's environment. A concerted effort is made to change the environmental contingencies—both positive and negative—related to substance use.

MDFT: This treatment is family focused and includes 12 weekly sessions to work individually with the adolescents and their families. MDFT focuses on family roles, other problem areas, and their interactions.

The interventions for MET/CBT5 and FSN are detailed in Volume 1 (Sampl & Kadden, 2001) and Volume 3 (Hamilton et al., 2001), respectively, of the CYT Series. This manual for CBT7 occasionally references its partner interventions (i.e., MET/CBT5 and FSN), and it explains and provides details on the sessions unique to CBT7. Like the other CBT manuals, this manual focuses on the development of interpersonal and self-management skills for helping to effect and maintain abstinence.

In each site of the CYT study, approximately 150 adolescents were systematically assigned to one of three interventions. At UCHC and Operation PAR they were assigned to the brief MET/CBT5 or one of the two other individual/group combinations. At CHS–CC, CHS–MC, and CHOP, adolescents were systematically assigned to the brief MET/CBT5 treatment or one of the two individual approaches of ACRA or MDFT. All conditions were replicated in two or more sites and were manual based with expert workgroups supporting them. Each group met weekly and consisted of six participants. All participants were assessed at intake and at 3, 6, and 9

months after intake. To validate subject responses to questions about use, urine tests and collateral assessments were done at intake and at 3 and 6 months after intake.

II. The CBT7 Approach to Cannabis Treatment: Background and Overview

Evolution and Purpose of Protocol

The additional sessions presented in this manual were developed to extend CYT's MET/CBT five-session intervention by seven group sessions. This allowed investigators to test whether adding seven coping skills training sessions provided in a group format would result in improved outcomes for treatment recipients.

Previous Applications of Cognitive Behavioral Treatment to Relevant Populations

In clinical trials, cognitive behavioral approaches to treatment have been demonstrably effective with other behavior- and mood-related problems experienced in childhood and adolescence, as well as for relapse problems of adult substance abusers.

Cognitive behavioral interventions are helpful to children and adolescents with behavior or mood problems and those with conduct disorder or subclinical delinquency. Cognitive behavioral trials with this population have yielded improvements in problem solving, self-control, prosocial behaviors, and positive communication that have been sustained for at least a year (Kendall et al., 1990; Kazdin et al., 1989; Sarason & Sarason, 1981; Camp, 1977; Sarason & Ganzer, 1973).

Trials with children and adolescents diagnosed with attention deficit/hyperactivity disorder (AD/HD) have been less successful. Although these trials yield temporary improvements for on-task behavior and self-control, the effects often last less than a year. The treatment effects also do not generalize to social situations and do not enhance the effects of medication (Abikoff & Gittleman, 1985; Brown, Wynne & Medemis, 1985; Hinshaw, Henker & Whalen, 1984; Kendall & Wilcox, 1980; Douglas et al., 1976; Meichenbaum & Goodman, 1971).

With respect to internalizing disorders, cognitive behavioral interventions appear effective with adolescents who meet the criteria for having depressive disorders. Not uncommonly, reduced rates of depression and relapse are sustained within these populations for at least 2 years (Hops & Lewinsohn, 1995).

Another type of client that seems to benefit from cognitive behavioral treatment is the adult aftercare recipient in recovery from a substance use disorder. For this population, the cognitive behavioral paradigm appears to be a useful educational method for helping to organize and anticipate stages of relapse. Of particular relevance to this manual is Marlatt and Gordon's (1985) cognitive behavioral model of relapse. Marlatt and Gordon propose that relapse is a sequence of stages that can be arrested when

appropriate cognitive behavioral techniques are introduced to halt the progress from one stage to the next. According to their stage model, triggers that generate cravings for a substance work synergistically with positive thoughts about a substance's satisfying effects to undermine resistance. By using self-talk and social support to check cravings and by mentally challenging the perceived benefits of use, adult aftercare patients can effectively prevent relapse and extend periods of abstinence.

Based on its success rate with children and adolescents with a variety of behavior or mood problems and with adult substance abusers, CBT was selected as an appropriate component of treatment for participants in the CYT study.

As also noted in the MET/CBT5 manual (Sampl & Kadden, 2001), the MET/CBT intervention described in this manual is an adaptation of adult treatment. The unique developmental tasks of adolescence play a role in substance use disorders and their treatment. Nowinski's 1990 book, *Substance Abuse in Adolescents and Young Adults: A Guide to Treatment*, provides a useful discussion of substance abuse in relation to adolescent development. Nowinski discusses the primary adolescent developmental task of individuation, in which adolescents develop identities separate from their parents or caregivers. During this individuation process, adolescents are especially likely to question what adults tell them. Using the MET approach minimizes the likelihood of provoking resistance, which might occur in a highly directive or confrontative therapeutic approach. As a result, the MET approach seems particularly promising for adolescent marijuana users. In MET the therapist works with the client's own marijuana use goal, helping to evaluate the benefits and disadvantages of abstinence versus continued use. This process supports the development of self-control, another key developmental task of adolescence (Nowinski, 1990).

Overview of Treatment Model/Intervention

Treatment Goals and Objectives

The ultimate goal of CBT7 is abstinence. Toward this end, CBT7 is administered with two broad treatment objectives in mind: (1) to teach adolescents how to use a broad spectrum of coping activities to help deal with problems, interpersonal conflicts, and negative mood states and (2) to teach adolescents how to anticipate and challenge the thoughts, cravings, and urges that impel marijuana use as a means to maintaining abstinence. The framework therapists use to promote these objectives is first to work with clients to identify a wide range of interpersonal and intrapersonal stressors, triggers, cravings, and urges that pull for impulsive/self-defeating behavior or for marijuana use. Therapists also teach coping skills that clients can use to weather stressful circumstances and maintain abstinence.

These objectives of CBT7 are mutually supportive and synergistic. Marijuana use can be seen as a maladaptive form of coping. Efforts to develop adaptive coping skills will have the subsidiary effect of reducing the need for cannabis as a coping agent. Likewise, by reducing or eliminating marijuana

use, adolescents learn alternative approaches to stress management that have greater potential for long-term benefit.

The overall goal of abstinence, however, deserves further clarification. In sessions 10 and 12, adolescents in CBT7 are taught to use cognitive behavioral strategies, first to abstain from marijuana and then to maintain abstinence after treatment is over. Declaring abstinence the ultimate goal of treatment, however, does not mean that it becomes a criterion for receiving treatment in the first place. Adolescents should not be removed from treatment for occasional use of marijuana or other substances (unless substance use escalates to a point where clinical deterioration is evident). They should be allowed to continue as long as they commit to working toward renewed abstinence. At the same time, clients should not be allowed to come to treatment if they are manifestly high on marijuana or other drugs, especially if the therapist deems them unlikely to benefit from the group or likely to tempt others to use. (See Coming to Group Intoxicated, page 30 in Section III: Overview of Treatment Session Components.)

In CBT7, the participant's ambivalence about the possibility of stopping marijuana use is considered normal. The therapist is encouraged to accurately reflect participants' mixed feelings about quitting marijuana. Therapists are encouraged to "normalize" ambivalence and concerns about quitting. They can provide feedback to participants, such as, "What you're feeling is not at all unusual, especially in these early stages. Many people have mixed feelings about quitting pot." Also, they can reinforce any self-motivational statements and indications of willingness to change. Participants may reconsider their resistance to change if they believe the therapist understands the reasons for being hesitant to change.

Theoretical Assumptions

The cognitive behavioral paradigm assumes that thinking, feeling, and doing are separate realms of human process that become associated through learning. Cannabis use, like any behavior, can be linked with thoughts, feelings, and other behaviors through direct experience or through observation. Associations can be strengthened by intense learning experiences or by placing certain thoughts, feelings, or actions in frequent proximity to use. When they are strong enough, associations can even serve as triggers (i.e., antecedents) that effectively cue or reinforce a person's desire (i.e., consequences) to use—even when that person is planning to abstain. From a cognitive behavioral perspective, for individuals to change their patterns of cannabis use, they should attend to the context in which they use, as well as to the decisions that lead to using. Taking a broad perspective on the context of cannabis use can improve one's chances for anticipating and thereby avoiding unintended relapse.

A second theoretical assumption in the cognitive behavioral framework is that teaching and consulting are appropriate ways of intervening with people who have mental health problems. As teachers, cognitive behavioral therapists use a classroom teaching style to help clients comprehend coping skills. They use experiential teaching methods to help clients internalize coping

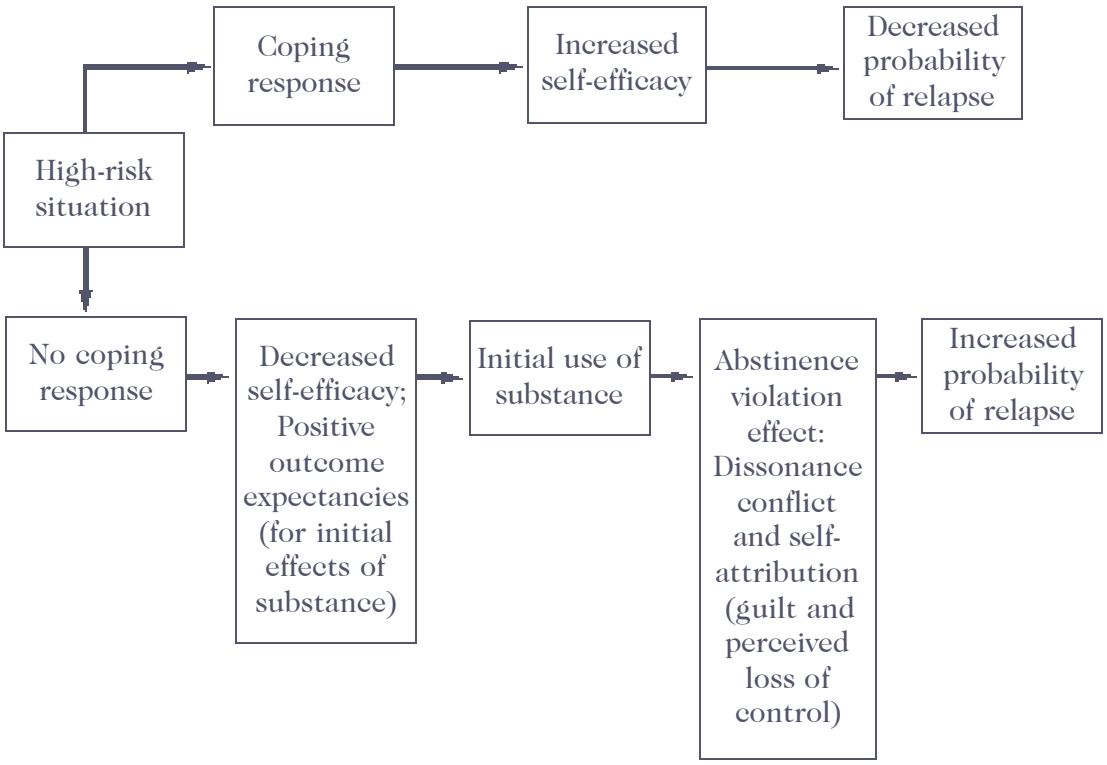
skills that are personally useful. As consultants, therapists tailor session content to problems raised by an individual or by group members. The cognitive behavioral therapist is not perceived as an expert by the client but rather as an ally who appreciates the difficulty of balancing personal emotions and ambiguous social demands and who is prepared to share ideas about how to deal with both.

Treatment Model

CBT posits that, for adolescent cannabis users to abstain from smoking, they must learn new ways of responding to feelings, states of mind, or situations that have led to use in the past and the internal dissonance that may arise as a consequence of using, despite earlier commitments to abstain.

Exhibit 1 suggests that individuals' confidence in their ability to abstain (i.e., their self-efficacy) derives from periodic exposure to high-risk situations that triggered or mediated use in the past. Using coping skills learned through CBT in these situations increases the likelihood that the adolescent will achieve a positive outcome such as a reward, reduced anxiety, abstinence, or discontinuance of use and, in turn, strengthen his or her *perception that a positive outcome is achievable*. The bottom trajectory of exhibit 1 illustrates the default sequence that occurs if the adolescent lacks coping skills or fails to use coping skills at the appropriate time. In this case, an ineffective response to the risky event yields disappointment (i.e., low self-efficacy) and emergent desire to remedy the situation with marijuana. Desire leads to use, and use further erodes the perceived ability to abstain.

Exhibit 1. Cognitive Behavioral Model of the Relapse Process



Source: Marlatt & Gordon, 1985. Copyright © 1985 by The Guilford Press.

In short, CBT is an intervention designed to teach adolescents alternative ways of coping with circumstances that were previously associated with use. The purpose is (1) to increase adolescents' range of coping skills and subsequently their perceived ability to abstain and (2) to replace cannabis use as a default option for coping.

Overview of Sessions

The MET/CBT5 intervention is described fully in Sampl and Kadden (2001). Exhibit 2 presents the five sessions of MET/CBT5 that always precede CBT7. Exhibit 3 presents the seven sessions of CBT7.

Exhibit 2. Five Sessions of MET/CBT5

Session Number	Modality	Time Period	Primary Approach	Main Topics
Session 1	Individual	60 min.	MET	Motivation Building (Sampl & Kadden, 2001, pages 32–40)
Session 2	Individual	60 min.	MET	Goal Setting (Sampl & Kadden, 2001, pages 41–51)
Session 3	Group	75 min.	CBT	Marijuana Refusal Skills (Sampl & Kadden, 2001, pages 61–67)
Session 4	Group	75 min.	CBT	Enhancing the Social Support Network and Increasing Pleasant Activities (Sampl & Kadden, 2001, pages 68–76)
Session 5	Group	75 min.	CBT	Planning for Emergencies and Coping With Relapse (Sampl & Kadden, 2001, pages 77–81)

Group sessions are held weekly and consist of six participants. Content descriptions of the five MET/CBT5 and seven CBT7 sessions are provided below.

Exhibit 3. Seven Sessions of CBT7

Session Number	Modality	Time Period	Primary Approach	Main Topics
Session 6	Group	75 min.	CBT	Problem Solving (pages 37–44)
Session 7	Group	75 min.	CBT	Anger Awareness (pages 45–57)
Session 8	Group	75 min.	CBT	Anger Management (pages 58–63)
Session 9	Group	75 min.	CBT	Effective Communication (pages 64–71)
Session 10	Group	75 min.	CBT	Coping With Cravings and Urges To Use Marijuana (pages 72–79)
Session 11	Group	75 min.	CBT	Depression Management (pages 80–91)
Session 12	Group	75 min.	CBT	Managing Thoughts About Marijuana (pages 92–100)

Session 1 includes motivational interviewing and focuses on establishing rapport and building motivation. The therapist explores the participant's reasons for seeking treatment, prior treatment episodes, previous attempts to quit, treatment goals, and perceptions of self-efficacy. A *personalized feedback report* outlines information provided on intake assessment instruments, highlights the adolescent's problems and concerns related to marijuana use, and compares his or her marijuana use with national adolescent norms. A sample PFR and instructions for filling it out can be found in appendix 4 of *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions* (Sampl & Kadden, 2001). The therapist reinforces indications of motivation to change and explores ambivalence, as it may pose a significant barrier to abstinence.

Session 2 reinforces the participant's motivation to change. The first session is summarized, and reactions to the material covered in the first session are discussed. The therapist and the participant collaborate on establishing a personalized plan for change. The therapist introduces the concepts of functional analysis and triggers, provides general information about participation in group therapy and the family support network (if applicable), and answers questions or discusses the adolescent's concerns.

Session 3 is the first group session and focuses on developing skills for refusing offers to buy or use marijuana. Participants discuss social pressure, the need for immediate and effective action, ways to say "no" quickly and convincingly, alternative activities, and avoidance of making excuses. The

therapist roleplays ineffective (passive, aggressive, passive-aggressive) and effective (assertive) responses. Roleplaying of risky situations is included.

Session 4 focuses on enhancing participants' social support network. The adolescents identify potential supporters, kinds of helpful support, and methods for improving social relationships and increasing support. The therapist models appropriate ways to seek support. Group members complete a social circle diagram and describe the support available from the people included in their diagram. Ways of increasing participation in appropriate pleasant activities may also be presented.

Session 5 concentrates on coping with unanticipated high-risk situations and relapses. The group discusses situations that could precipitate relapse. Participants are advised that smoking marijuana may produce feelings of guilt and shame. The adolescents are encouraged to view these situations as learning experiences that contain information on preventing future marijuana use. Group members develop a personal emergency plan and identify steps for dealing with a slip or relapse.

Session 6 focuses on developing effective problem-solving skills using a five-step problem-solving model. The group members use a group exercise to apply the model and respond to feedback from their peers and the therapist.

Session 7 presents anger awareness and relaxation skills training. Participants are cued to recognize early indicators of anger and learn the difference between internal and external events that trigger anger. A verbal practice exercise helps participants process the session content. Progressive relaxation techniques are taught.

Session 8 teaches techniques for managing anger and expressing it appropriately. Participants are encouraged to use problem-solving skills to address situations that trigger anger. The therapist models appropriate expressions of anger, and group members roleplay to help process session content.

Session 9 introduces components of effective communication: active listening, assertiveness, and receiving criticism. Adolescents are taught to reflect on their discussions with others and are encouraged to assert their thoughts, beliefs, and feelings, while respecting that others may think, believe, or feel differently. Techniques used include therapist modeling and group roleplays.

Session 10 presents coping options for handling craving and urges for marijuana. Participants learn to identify triggers; to use a daily log for documenting the intensity, length, and source of urges; and to use techniques for coping and resisting urges such as self-talk, talking to friends, and engaging in distracting activities.

Session 11 is concerned with feelings of depression and their management. Topics include early recognition of feeling down, the effects of automatic negative thoughts, and techniques used to substitute positive thoughts for

negative ones. Participants are encouraged to use problem-solving skills to resolve situations that contribute to sad feelings.

Session 12 returns to the central issue of managing thoughts about marijuana. Participants are reassured that these thoughts are common to recovery and that having thoughts is not the same as acting on them. The therapist proposes cognitive behavioral techniques for managing thoughts about marijuana and reviews the 12 most common excuses for relapse (Marlatt & Gordon, 1985). Issues related to termination of therapy are discussed.

D: A Composite Case

In keeping with the MET/CBT5 + CBT7 approach and to introduce the concepts for practice in real life settings, the following composite case portrays the encouragement adolescents receive at sessions to try an extended period of abstinence from marijuana. The composite case describes how youth are encouraged to evaluate the potential impacts of marijuana use on their lives. In this case the therapist tolerates the adolescent's ambivalence about change. The therapist does not try to force abstinence but helps the client to understand the risk associated with continued use.

The CBT7 coping skills therapy is designed to remediate deficits in skills for coping with antecedents to marijuana use. Individuals who rely primarily on marijuana use (or other substances) for coping have little choice but to resort to substance abuse when the need to cope arises. Skill deficits are viewed as central to the relapse process; therefore, CBT focuses on the development and rehearsal of skills.

D is a composite of several real cases from the CYT study. This composite was created to help model typical client responses to the MET/CBT5 + CBT7 protocol.

D's grandmother, Mrs. M, brought D to treatment shortly after learning about the program from a newspaper advertisement. D had recently come to live with his grandmother after deciding that he could no longer live with his mother, who, according to Mrs. M, "is a heavy drinker and a hard woman to make listen." Shortly after moving in with his grandmother, D was arrested for possession of marijuana. To keep her grandson out of detention, Mrs. M brought him to treatment, hoping that the judge would note their initiative at D's court date.

D presented to treatment as a verbal, neatly dressed, 16-year-old white male. At intake, he reported he had first experimented with marijuana at age 13. He admitted to "smoking a lot" in recent months—almost every other day in the past 90 days. He endorsed one symptom of past-year cannabis dependence (i.e., spending a lot of time getting marijuana) and two symptoms of abuse (i.e., continuing to use despite failing to meet his responsibilities at home and school and despite repeatedly getting involved in fights and with the law). Although D's endorsement indicated

a conduct disorder (i.e., he lied or conned to get the things he wanted, was truant from school, and stayed out later than allowed), D endorsed no items indicating a persistent pattern of aggressive behavior toward others. D reported his school performance as adequate (i.e., mostly C's) although he contended that "I can do better than that."

Prior to CBT7, D attended all his scheduled MET/CBT5 appointments. During his first MET session, he expressed skepticism when told that he smoked more marijuana than the average adolescent, saying that he knew several people his age who smoked more than he did. Nevertheless, he said that he felt that he had been smoking too much lately and voluntarily made the connection between smoking a lot and "forgetting stuff." Although not ready to abstain, D said that he wanted to cut his use in half—using mostly on weekends. He planned to abstain during treatment so that his urine tests for probation would be negative. At the end of the feedback session, D's therapist asked D about the 50-percent chance D had given earlier regarding confidence in his own ability to change his behavior. D unilaterally chose to improve that rating to an 80-percent chance.

Session 6: Problem Solving. By the time the CBT7 sessions began, D's court date was scheduled, and he was assigned to a probation officer. He was in the third week of the fall high school semester and was going to afternoon football practice. During session 6's review of client status, D stated he was glad that he was spending time with the football team, adding "they use a lot less than the guys I was hanging out with this summer." The therapists congratulated D for gathering friendly support to help him reach his goal of not using. D appeared attentive during the session on problem solving and offered three solutions during the brainstorming exercise to help solve a problem that another participant was having with her boyfriend. The therapist made sure to write D's ideas on the blackboard at the front of the room where he could see them.

Session 7: Anger Awareness. The following week, D reported that he attended a party the previous Sunday. He did not use despite several opportunities "because I know I'm going to drop a dirty urine and the judge is going to send me to detention." Although not the best example of problem solving, the therapist used this as an opportunity to build D's confidence. She suggested he had actually solved a problem situation by considering options just as he had during the previous week's group exercise. D accepted the idea and stated, "I've been thinking things through a little more, I guess." However, during the session, D was unconvinced about the usefulness of the material on anger awareness, stating, "I just get mad when I get mad. It's not because I'm tired or anything." After D completed *Activity Sheet 2: Conducting a Self-Interview*, the therapist asked him whether he could see possibilities for anticipating anger. He remained unconvinced. He seemed more receptive to the usefulness of session 7's relaxation training. The therapist noticed that after providing a urine sample, D took his *Real Life Practice Exercise: Relaxation Technique* handout but left the materials on anger awareness behind.

Session 8: Anger Management. Before the start of the session, the therapist met privately with D to tell him that his urine test indicated the presence of marijuana. D was surprised and said that he was certain that he had been abstinent for the prior 3 weeks. Realizing that D was feeling anxious about pending drug screens at probation, the therapist permitted him to give a second sample. That evening, during the discussion about anger management, D again stated that he could not see himself affecting his own anger. The therapist asked D which of the anger management steps made the most sense to him. D answered "Step 1: Chill Out" and compared it with "time out." After helping D explore how D uses timeouts, the therapist encouraged him to use the *Real Life Practice Exercise for Anger Management* handout to see whether he could recognize his anger triggers as they occurred.

Session 9: Effective Communication. Before the start of the session, the therapist reported to D that his second urine sample did not indicate the presence of marijuana. D was visibly relieved. He stated during the review session that he had given his first urine specimen for probation and he hoped it would test the same. The therapist congratulated D and encouraged him to stick with the goals he had set for himself. During that evening's discussion about effective communication, the therapist noticed that D was frequently off-topic and talked to other group members during the session. The therapist partially succeeded in reengaging D during the roleplay about responding to constructive and destructive criticisms.

Session 10: Coping With Cravings and Urges To Use Marijuana. During the review session, D reported that he used three times at a party that he threw at his grandmother's house while she was away visiting a relative. When asked by the therapist what had triggered the use, D replied that he was "feeling kind of bored and being around all those guys and just thinking 'Well, why not? They're having fun at least.' " The therapist reflected back to D that boredom and friends using had triggered his use, and the therapist asked what the positive and negative consequences of using had been. D reported that he felt good at the time but that now he was afraid that his probation officer would ask for another urine sample. After probing further, the therapist learned that D had left a pile of empty beer cans "in the garage where my grandma found them and she yelled at me." When asked about his response to his grandmother's reaction, D reported that he sat in his room for an hour. "Like a timeout?" the therapist asked. "Yes, kind of like that," D stated. Before turning to the evening's agenda, the therapist pointed out to the group that D used the first and most important step of anger management. She suggested that D learned about some important triggers for using such as boredom or being with friends who use. He was now in a position to anticipate and avoid triggers.

Sessions 11 and 12: Depression Management and Managing Thoughts About Marijuana. In sessions 11 and 12, the therapist noticed D became increasingly off-topic as he became friendlier with other group members and as he looked forward to the end of treatment. His urine sample from session 11 indicated, unsurprisingly, the presence of marijuana. Nevertheless, D reported that he was paying attention to triggers. He

stated he would not use during the final weeks of treatment so the urine sample for his probation officer would be free of marijuana.

On his last real life practice exercise, D wrote that the benefits of not using marijuana were that he did not have to go to detention and that he had more money in his pocket. His high-risk situations were being with friends who use and being bored.

During termination, D stated that the most important skills he had learned were problem-solving and relaxation skills. He encouraged other members of the group to stick with their goals and restated that his goal was to complete probation, to use only on weekends, and never to use as much as he was using when he started treatment.

As part of the therapist's termination feedback, the therapist told D she was impressed that he came to all his scheduled sessions (even when he wasn't sure he wanted to come). She presented him with a certificate for finishing treatment. She commended D for abstaining during the past 3 weeks by anticipating social situations that placed him at risk for using. She added that D seemed more attentive and expressive during that time—possibly due to abstinence.

Key Concepts of CBT7

The key concepts presented in CBT7 are problem solving, affective management, communication skills, and relapse prevention.

Problem Solving

Problem solving is addressed in session 6. This session lays important groundwork for later sessions by presenting problems as a normal part of daily living and by reassuring participants that they can solve problems if they take the time to do it. According to D'Zurilla and Goldfried (1971), mental health and behavioral problems are often the products of hasty problem solving. Most people (drug users included) tend to narrowly interpret problem solving as fixing the problem instantly (e.g., "If I smoke pot, I won't feel bored anymore."). Although this approach may produce immediate gratification, it may lead to anticipated negative outcomes. Careful problem solving may not produce gratification immediately, but it does so eventually. The benefit of careful problem solving is that one sees things improve gradually, without having good consequences canceled out by negative ones.

The session on problem solving follows D'Zurilla and Goldfried's (1971) prescription of breaking problem solving into the following steps: general orientation, problem identification, generation of alternatives, decision making, and verification. Adolescents are encouraged to think through one step before moving to the next. The critical distinction is between the linear process of *getting the right answer* and the creative process of *generating and evaluating options*. CBT7's didactic style may give adolescents the impression they are in a classroom and are being called on to give the right

answer. Therapists counter this impression, however, and elicit creative and even outlandish ideas from the group—especially when generating alternatives.

Affective Management

Affective education, presented in sessions 7, 8, and 11, helps adolescents regulate negative emotions that intrude on their attempts to solve problems. The components of affective education are emotional identification and management. In emotional identification, adolescents learn to recognize physical reactions and behaviors that signify the presence of latent or neglected anger or depression. In emotional management, participants learn how to check escalating anger or depression and to refocus their energies on problem solving.

Modeling and roleplay are useful approaches for teaching affective management. These forms of communication are more effective than verbal accounts in conveying the full gestalt of affective experience. These techniques enable the therapist to add inflection, tone of voice, body language, and facial expression to emotional portrayal and to exhibit the broad range of emotional cues that participants must use to tap into their feelings. Roleplay is a natural counterpart to modeling. Through roleplaying, adolescents can apply what they learn from the modeling of coping strategies to personally meaningful events.

Communication Skills

Effective communication skills are the adolescent's first defense when attempting to deescalate emerging conflict and move in the direction of problem solving. In session 9, teenagers learn coping skills (listening, rephrasing, reflecting) to facilitate communication, and they learn to distinguish an assertive posture from less adaptive patterns of relating. Although the goal of communication skills training is effective communication, the process by which each teenager reaches that goal depends on the nature and severity of his or her interpersonal deficits. For aggressive, externalizing teenagers, developing a more effective communication style means enhancing receptive language and raising personal awareness of reciprocity and boundaries. For passive, internalizing adolescents, improving communication means developing an assertive interpersonal style and attending more deliberately to positive feedback from others.

Relapse Prevention

The approach to relapse prevention embraced in sessions 10 and 12 is modeled on Marlatt and Gordon's (1985) cognitive behavioral approach to relapse prevention for adult substance abusers in recovery. This model breaks the process of relapse into a sequence of events, thereby highlighting crucial moments when coping skills can be used to help strengthen the resolve to abstain. Triggers such as a negative emotional state or proximity to friends who are high are an indication that a coping response is needed. When faced with a trigger, adolescents can use coping skills such as self-talk, social support, or distraction to help combat their cravings or urges.

Triggers and cravings are often accompanied by positive beliefs about the good feelings associated with use or the relief that smoking marijuana provides. To help resist these beliefs, participants can use thought changing, self-distraction, social support, or a simple delay of action.

Tailoring the Treatment to the Client

Adolescents vary in their coping deficits and in their capacities to learn. Although CBT7's general objective is to expose participants to the intervention's core content, the emphasis and style of the presentation should be tailored to meet the unique needs and capabilities of each participant. When adapting the intervention for a client, the therapist should consider four crucial client characteristics: pathological coping, severity of use and symptoms of withdrawal, cognitive functioning, and cultural factors. These characteristics are discussed below.

Externalizing Versus Internalizing Disorders

Presumably, adolescents are in CBT7 to learn how to deal more effectively with life problems, and improved coping is a goal of all participants. Some clients may have adequate coping skills and need only to enhance strategies they are currently using or work on a few areas of weakness. However, a significant number of adolescents enter treatment with coping styles that are maladaptive or pathological.

Maladaptive styles can be loosely categorized by their association with two broad classifications for childhood or adolescent disorders: externalizing disorders (e.g., oppositional defiance, conduct disorder) and internalizing disorders (e.g., depression, anxiety, posttraumatic stress disorder). These two broad classifications of disorders pose unique challenges to the therapist in his or her efforts to help adolescents develop effective coping skills.

Impulsivity and aggression are signature coping strategies of externalizing adolescents. Swept away by their own volatile reactivity, externalizers tend to miss opportunities for reflection or consideration of options before taking action. If they are to learn to use techniques for problem solving, emotional sensing, and reflective listening, they must first learn to stop and think before acting. Therapists must remind them that action is rarely the first step in any effective coping strategy. Action often is the last step, taken after sufficient time has been used to think through options.

Internalizing adolescents face different challenges, that is, self-abasement and social isolation. They tend to harbor low expectations about their ability to cope and are generally pessimistic about forecasting the consequences of their efforts. In social relationships, their beliefs in their own worthlessness override evidence of acceptance by others. To work effectively with such clients, therapists have to challenge clients' entrenched perceptions of fatalism and low self-esteem and positively reinforce acknowledgment of personal achievement. When asking internalizers to roleplay, therapists should encourage them to practice an assertive interpersonal style and to

balance the attention they pay to criticism with attention to the positive feedback they receive from others.

Severity of Use and Symptoms of Withdrawal

The length and severity of recent marijuana use moderate the likelihood that a participant will successfully abstain from using marijuana in the future. When assessing for client vulnerability to relapse, therapists are advised to assess the frequency of use during the past 90 days and to note the diagnostic criteria each client endorses for cannabis disorders. Clients who report frequent use and who endorse dependence items are more likely than others to be struggling with multiple triggers, urges, cravings, and obsessive thoughts about marijuana.

Beyond considering risk factors, therapists should assess how congruently clients' perceptions of vulnerability coincide with actual risk. If an adolescent reports using heavily in the past, reports symptoms of dependence, and then denies feeling at risk for relapse or loss of control over his or her use, the participant is doubly at risk for relapse because of his or her lack of concern or vigilance. To help generate concern for potential relapse, therapists should follow client use patterns closely during the 2 months of treatment that take place before relapse training in sessions 10 and 12. By attending to any reported use and objective screening results, therapists may eventually be able to direct a client's attention to discrepancies between his or her unjustified optimism and continued use.

Participants reporting more severe use may need to discuss withdrawal symptoms such as flulike symptoms, increased anxiety, or difficulty sleeping. Therapists can reassure these adolescents that withdrawal symptoms are common 12 to 24 hours after their last use and that the symptoms usually last less than 2 weeks. The therapist can encourage adolescents to use strategies such as relaxation techniques to relieve their anxiety or decrease caffeine intake to reduce insomnia. If participants anticipate having a very difficult time based on previous experience, or actually report experiencing severe withdrawal symptoms, the therapist may request permission to discuss the problem with their parents, primary care physicians, or psychiatrists. However, a referral to a primary care physician or psychiatrist should be made only in extreme circumstances (Steinberg et al., 1997, pages 23–24).

Cognitive Functioning

Because participants in CBT are expected to verbally and conceptually mediate their coping responses to interpersonal and intrapsychic stress, those diagnosed with cognitive deficits (e.g., attention deficit disorder) may have difficulty comprehending and learning some of the skills described in this manual. When gauging a participant's cognitive readiness for treatment, the therapist should not equate the participant's cognitive deficits with cognitive immaturity or the lingering effects of heavy marijuana use. Teenagers who are cognitively immature or whose short-term memory is temporarily compromised by lingering tetrahydrocannabinol (THC) may initially struggle with the therapy content but should eventually be able to

grasp essential concepts. However, participants with enduring cognitive deficits may need additional help to understand concepts such as triggers or problem solving. With these participants, therapists are encouraged to be more task specific when developing treatment goals, to use additional concrete and visual examples, to model the desired response more frequently, and to use rewards for helping clients notice personal successes.

Cultural Factors

Ethnic and cultural awareness is important to the competent delivery of treatment to minority populations. An individual's ethnic or cultural context is important to consider when evaluating his or her marijuana dependence or abuse. "A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge normative variations in behavior, belief, or experience as psychopathology" (American Psychiatric Association, 1994, page xxiv). According to Zweben et al. (1998, pages 12–13), "The clinician needs to be sensitive to ethnic and cultural problems that may cause problems in the diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological)." Although this manual does not contain cultural sensitivity training, therapists are encouraged to attend any relevant trainings available to them.

Compliance

Slips and Relapses

A slip is a brief, time-limited use of marijuana after a period of abstinence or a brief violation of a plan to cut down on use. A relapse is a longer period of sustained, and often heavy, use. Therapists can help a participant deal with slips by examining the events leading up to them and by identifying triggers and the participant's reactions to them. The slip can be viewed as a learning opportunity. Questions for the participant might be: "Did you have expectations that using marijuana would change something or meet some need?" and "Did anything happen after you used that might influence your using again in the future?"

When a participant relapses, his or her immediate response might be "I messed up, I'm a failure, and this treatment isn't working." Therapists are advised to challenge such self-defeating thoughts by commending the participant's honesty and by stating that occasional relapses are normal; they are not evidence of treatment failure or that the participant is a failure. The therapist might say the following to the participant:

> Individuals may find it hard to stay completely abstinent and may use again after several weeks of abstinence. It's pretty common and nothing to feel ashamed about. You were abstinent for about 3 weeks before that slip. I'd expect with all you have learned, you'll be able

to stay clean longer this time. What are some things you can do to remain abstinent longer?

Some participants quit treatment after a slip or relapse. Participants should be advised that, even with efforts to maintain their abstinence, some may slip. Although participants are told never to come to a session high, they should be strongly encouraged to continue attending after a slip or relapse. Resuming treatment can prevent additional relapses and serve as a reaffirmation of a personal commitment to treatment. In addition, therapists should take care that participants understand that allowing them to return to treatment after a relapse does not give them permission to use marijuana.

Urine Test Results

Urine is tested for drugs at sessions 3, 7, and 11 of MET/CBT5 + CBT7, before sessions begin. Therapists should discuss the test results with clients individually before or after sessions 4, 8, and 12. If the results are negative (i.e., drugs are not present), therapists can provide strong positive reinforcement and support. Therapists can encourage continued involvement in activities that are incompatible with drug use, as well as continued association with persons who do not place the participant at risk for drug use. They might also ask about problems encountered during this period of abstinence, such as cravings for specific drugs. If participants used coping skills learned in therapy, therapists should encourage continuing use of the new techniques.

If the results of the urine test are positive (i.e., drugs are present), the therapist should review the circumstances and context of the drug use with the participant. For example, the therapist and participant can identify external factors (e.g., persons, places, things) and internal factors (e.g., cravings, emotional distress) associated with the recent drug use. The therapist can encourage use of problem-solving techniques and coping skills to manage factors that contributed to drug use and to develop alternative ways of handling them.

Missed Sessions

If a participant misses a session, the therapist should attempt to contact the person by telephone within 24 hours to determine the reason for the absence. If the participant cannot be reached by telephone within 7 days, the therapist should send a brief letter. If there is no response to the letter within 3 weeks, the therapist should refer the case to a supervisor.

If all group members but one are absent, the therapist should conduct a 45-minute individual session with the attendee and cover the material planned for the group session. When confronting participants who have missed sessions, therapists should explore obstacles to their treatment or their possible ambivalence toward treatment. Steinberg et al. (1997, page 20) commented:

Many participants miss sessions because: (a) they slipped and are simply too embarrassed to admit their "failure" to the therapist, or (b) they are ambivalent about complete abstinence. Careful inquiry by the therapist will reveal which of these situations is the case. Ambivalence indicates a need to return to a MET focus, that is, rolling with resistance, reframing, and revisiting treatment goals. If the participant misses sessions because of fear of admitting failure, the therapist should reiterate that occasional "slips" are fairly common, and often signal a high-risk situation that hasn't yet been directly discussed during sessions.

Clinical Issues

Therapist Self-Disclosure

Clients often ask therapists about their own past use of marijuana. Therapists should consider such questions carefully, as they may originate from an underlying concern such as, "Will you, the therapist, be able to understand me, and can I get the kind of help here that I need?" (Steinberg et al., 1997, page 24). Therapists should not, in fact, disclose their previous use or nonuse of marijuana. Although self-disclosure may be a matter of preference in general clinical practice and is often used to build rapport, the clinical strategies provided in this intervention are considered sufficient and are not enhanced through self-disclosure.

Threats To Harm Oneself or Others

Threats to harm oneself or others should be addressed separately from the group whenever possible and should be brought to the attention of the clinical supervisor as soon as possible. A supervisory review will help determine the best clinical response, the ethical and legal responsibilities, and whom to warn or how to intervene. It should trigger an immediate reevaluation of the severity of the problem and modality placement.

Clinical Deterioration

It is inevitable that some participants will suffer setbacks in their personal or interpersonal functioning. It is imperative that accommodations be made to provide support or referral services for medical, psychological, or substance abuse services when they are needed. Offering referral services when clients express a need is an informal incentive to participation that seems important to some individuals (Zweben et al., 1998, page 62).

Therapists should refer adolescents to a clinical supervisor if they observe either of the following:

- Clinical deterioration in multiple spheres of an adolescent's life due to increased marijuana use
- Significant deterioration in a single sphere of a participant's life due to comorbid issues.

Administrative Issues

Extended Waiting Periods

If the waiting period between a participant's individual meetings with a therapist and the start of his or her attendance in a CBT group is longer than 2 weeks, therapists should maintain contact with weekly phone calls to help prepare the adolescent for the treatment and to assess any changes in the adolescent's status that might require immediate face-to-face contact. If such a change is noted, the therapist should discuss this concern with a supervisor.

Preventing Attrition

To prevent attrition, therapists should explore any potential obstacles, such as transportation problems, child care issues, school schedules, court involvement, or vacations, and discuss them with participants in the introductory meeting or session. Therapists may wish to explore any previous treatment attempts or failures and should encourage participants to discuss any present thoughts of leaving treatment. If participants express disillusionment with treatment, therapists can offer reassurance that progress in treatment is rarely steady and that most participants experience hopelessness, anger, or frustration at some point in the process.

Collateral Services

Participants receiving concurrent services from other agencies may participate in CBT7. These additional services should, however, be documented (e.g., in progress notes).

Relevant Ethical and Legal Issues

Admission to Treatment: Legal Aspects and Policy

Federal statutes regarding underage access to treatment and control of information give the final authority over these matters to the States. Practitioners using this manual should consult with representatives of their local departments of children and families and juvenile court systems to determine adolescents' rights regarding accessing treatment and releasing information with or without the consent of a legal guardian.

Duty To Warn

Many addiction professionals believe they have a professional and ethical duty to prevent a crime if they learn that an adolescent may pose a serious risk of violence to someone else. A therapist can be held legally accountable to warn either the potential victims or the police. The trend is toward "taking reasonable steps" to protect a potential victim. Federal and State laws differ regarding the "duty to warn," and clinical staff are strongly encouraged to become familiar with both sets of laws.

Reports of Abuse

It is common for clinical staff to learn about physical or sexual abuse, neglect, or maltreatment of a minor. In all States, therapists are obligated to report any history, recent event, or imminent danger of physical or sexual abuse, neglect, or maltreatment of a client under the age of 18. If a therapist learns of such abuse, the case should immediately be referred to a supervisor. If a supervisor is not immediately available, the therapist should notify the person in charge of clinic operations. The consultation will help determine whether there is justifiable cause for filing a report with the local authorities.

Disclosure of abuse information "increases the likelihood of noncompliance because disclosure of some facts may result in unwanted social or legal consequences (for example, reporting suspected child abuse to protective services)" (Zweben et al., 1998, page 63). Clients should be told that counselors will report certain behaviors (such as plans to hurt themselves or someone else), and clinical staff should report any problems, complaints, or concerns that participants voice about this policy.

Session Documentation

Appendixes 2 and 3 of this volume include forms (adapted from Steinberg et al., 1997) to assist therapists in documenting delivery of treatment and to assist supervisors in certifying and monitoring therapists in their administration of CBT7. The appendixes include the following:

1. A MET/CBT5 + CBT7 Treatment Plan, which is an optional clinical form kept in the chart

2. A Therapist Self-Rating Form, which is completed by the therapist at the end of each session, allowing the therapist to document changes in a participant's clinical status as well as to rate the adequacy with which each particular intervention was delivered

3. A Supervisory Rating Form, which is completed by a supervisor after his or her review of audiotaped and videotaped sessions as part of the certification process for CBT7. (For a complete list of certification criteria for CBT7, refer to the Recommended Certification Guidelines in appendix 3). The supervisor uses this form to rate the intervention components.

III. Overview of Treatment Session Components

This section provides a detailed outline of each CBT7 intervention. For each session, there are a rationale, guidelines for presenting coping skills, and activities for therapist modeling and client roleplay. The outlines are not intended as a rigid structure but rather as scaffolding to help shape the therapy event into a learning opportunity.

The CBT7 interventions follow a basic sequence, as given below.

1. Review of client status
2. Review of real life practice
3. Rationale for coping skill
4. Skill guidelines
5. Group exercise
6. Reminder sheets and real life practice exercises.

Urine testing to ensure clients' compliance with abstinence is recommended at sessions 7 and 11. At sessions 6 and 10 clients are told that urine testing will be conducted at the next sessions. The results can be discussed with clients at subsequent sessions (i.e., sessions 8 and 12), immediately before or after the session. Should the therapist feel the need to retest on separate sessions, urine collection may be done at those times as well.

The session content is presented in a classroom format. The setting and session agenda are arranged to remind the six participants that they are attending a lesson for which their attention is required. The therapy room should be quiet, free of distractions, and equipped with a blackboard, white-board, or large posterboard. At each session, review sheets and homework assignment handouts are distributed to help reinforce the material.

Each cognitive behavioral group session focuses on a particular coping skill. A poster of the skill should be hung where all participants can easily read it. The poster for the current session should be displayed prominently so the material captures the participants' attention. Appendix 1 contains miniatures of the session posters, as well as two general posters: one describing the mission and assumptions of cognitive behavioral therapy and one listing the group therapy rules.

The sessions include sample presentations, referred to as "talking points," for the therapist. The talking points provide information needed to accomplish the goals of the session. Group participants may not understand all of the words and concepts used in the talking points. The therapist is encouraged to assess the participants' ability to grasp the terms and concepts introduced and to paraphrase the talking points as necessary.

Manual Adherence

Therapists should be thoroughly familiar with the contents of a session before beginning the presentation. While allowing for some degree of individual

therapeutic style, therapists should cover issues in the manner in which they are presented.

Review of Client Status

Clients may experience many problems with marijuana and abstinence over the course of treatment. Although the material in CBT7 is prescribed, ignoring participants' real life problems runs the risk that treatment will be viewed as peripheral or irrelevant to participants' real needs. Therefore, each session should begin with a 10-minute review of the clients' status. This component provides a brief period of supportive therapy for participants to discuss their current problems related to marijuana use or abstinence. It also provides the therapist with the opportunity to support participants who are having difficulty and to congratulate those who are achieving success.

The general rule is that the opening discussions should be structured along behavioral lines, consistent with a skills-training approach. A problem-solving format—which involves clearly specifying the problem, brainstorming possible ways of dealing with it, and selecting possible solutions—is recommended.

Participant Behavior Issues

Disruptive Behaviors. To minimize problems and clarify expectations for appropriate behavior in the group, therapists are encouraged to (1) define appropriate norms about language (e.g., profanity, "drugalogs" glorifying addiction), (2) define appropriate dress standards (prohibition of drug or gang symbols on clothing), and (3) promote recovery-based language.

Therapists can manage disruptive behavior by (1) restating group rules at each session, (2) providing constructive criticism, and (3) invoking constructive criticism from group peers. Interventions during or immediately following the group session to modify the disruptive behavior and remotivate the participant should be attempted before expulsion from the group is considered. If a participant repeatedly violates group rules, the therapist can ask the participant to leave the group for that session. If expulsion from the group is necessary, the therapist should reevaluate the type and level of service required by the participant.

Lateness. Therapists should convey the attitude that sessions are too important to waste by being late and should make reasonable efforts to help participants solve whatever problems may be causing them to be late. Participants should not be allowed to enter group sessions more than 15 minutes past the scheduled start time. If a participant is more than 15 minutes late, the latecomer will need to make up the session.

Coming to Group Intoxicated. Participants are asked to refrain from smoking marijuana on the days of the assessment and therapy sessions. This expectation should not be communicated in a punitive way but from the perspective that an adolescent has a greater chance of benefiting from the session if he or she is not under the influence of marijuana or other substances. This

message should be communicated during admission to treatment, during assessment, and during the first therapy session.

Participants who are under the influence of alcohol, cannabis, or other nonprescribed drugs will not be allowed to participate. This situation calls for (1) a detoxification assessment, (2) notification of a parent or guardian because of a potential safety or liability issue, and (3) evaluation of the potential threat to public safety (e.g., a participant driving after the session). If the therapist reschedules because of a participant's intoxication, arrangements should be made for safe transportation home (if the participant drove to the session) with a family member, with a friend, or by arranging for public transportation (Steinberg et al., 1997, page 22).

If a participant admits to using on the day of a session, the therapist needs to make a clinical judgment about whether the adolescent should be asked to leave. For example, if the participant appears to be intoxicated (e.g., is having difficulty concentrating on the session content, seems to be using unusually tangential speech patterns, acknowledges not being in a state to participate, or is openly defiant of abstinence as a treatment goal), the therapist should escort the participant to a staff member who can make arrangements for transporting the adolescent home. If the therapist determines that the participant seems able to participate meaningfully in the session, then the adolescent may remain. Anyone asked to leave a group is encouraged to return to the next session sober and continue in treatment (Steinberg et al., 1997, page 23).

Review of Real Life Practice

Following review of the clients' status, therapists spend 10 minutes reviewing coping skills homework assigned in the previous session. Taking the time to review assigned exercises helps establish the expectation that homework is to be completed and that coping skills practiced during sessions are to be practiced outside treatment. Even in the absence of completed assignments, review time gives therapists the opportunity to assess clients' retention of past material.

Rationale for Coping Skill

When presenting a particular skill, therapists start with the rationale. The rationale provides an explanation of why a particular coping strategy is relevant to maintaining abstinence or managing life problems. The rationale outlines reasons for learning about the new coping skill and seeks to convince the adolescent that the skill is relevant to his or her own life. Therapists discuss how the skill might be applied directly to deal with problems that adolescents have raised in the group.

Skill Guidelines

After presenting the rationale, therapists review skill guidelines. These guidelines can be used as steps or approaches to implementing a target coping skill. Participants are encouraged to read the guidelines aloud, as

well as question and interpret what they read. Participants who doubt the usefulness of guidelines are encouraged to be specific about their criticisms and identify situations in which they may or may not be useful. Therapists work with participants to identify concrete examples of situations in which the guidelines can be used. Group exercise and practice are used to reinforce the new skill.

Group Exercises

Group exercises are prescribed in each treatment session to help participants internalize and actualize the material being taught. Although not always stated explicitly in the text, an underlying principle of this component is that learning can be enhanced if therapists use the techniques of modeling and roleplaying to engage adolescents in the group exercises. These techniques provide clients with a more immediate sense of the skill being applied. Participants then imagine or roleplay scenes based on personal experience to help ground the skill in real life events.

Modeling

In addition to teaching clients about coping skills, therapists are encouraged to model, or act out, effective coping strategies to enhance their verbal explanations. Clinical trials find that modeling increases teenagers' understanding and appreciation of cognitive behavioral concepts. The key guidelines of modeling are to (1) stay in full view of participants, (2) think out loud so that participants can *hear* you state the logic of a coping strategy, and (3) avoid conveying the idea that coping leads to immediate results. The desired message is that coping is not a quick fix or panacea but an approach that yields benefits when applied persistently and consistently.

Beyond prescribed modeling, serendipitous opportunities to model may occur. A group disagreement may provide an ideal opportunity to model effective communication skills. Problems that arise during the session, such as supply shortages or transportation difficulties, may serve as opportunities to model problem solving.

Roleplay

Roleplay is explicitly prescribed in only two of the sessions (i.e., sessions 8 and 9), but therapists are encouraged to use roleplaying whenever there is a perceived need to facilitate understanding of a coping skill. Roleplay is therapeutically significant at two levels. First, it is a learning event. Low-functioning or disengaged participants may, at first, exhibit only a superficial understanding of the coping strategy by parroting what the therapist says. Roleplaying, however, helps internalize and actualize learning into a practical, usable skill. Participants who are high functioning or more engaged are more likely to easily apply coping skills to specific demands of life problems because of this roleplaying experience. Second, roleplay is therapeutically significant as a disclosure event. Through roleplaying, teenagers can be made more aware of life stressors. Therapists are advised not to press for disclosure but to allow adolescents to disclose stressors at their own pace.

Participants who present as shy or uncomfortable with disclosure at first may choose to roleplay hypothetical events until they are ready to move to personal incidents.

Although roleplaying may involve standing in front of a group of people and acting as if a situation were really occurring, going to such lengths is not always necessary. Roleplaying, in the present context, can involve as much as an actual performance of a coping skill or as little as stating out loud what one might say in a given situation or to a particular person.

To encourage roleplaying among clients, therapists should start by having them generate problem situations of moderate difficulty and only later have them move to more difficult situations. Therapists can use the following strategies to help participants generate problem situations:

1. Ask participants to recall a recent situation in which use of the new skill would have been desirable (e.g., a participant wanted to speak up about something but couldn't, another screamed at his mother when a simple request would have worked better).

2. Ask participants to anticipate a difficult situation that may arise in the near future in which the skill could be used (e.g., a participant's friend keeps borrowing clothes without asking and the participant wants to be able to tell the friend to stop).

3. Suggest an appropriate situation based on knowledge of a participant's recent circumstances.

4. Help participants generate details about a given situation by identifying its location, the key figures involved, and the essential problem being faced.

In roleplay and group exercises in general, the key to successful teaching is processing what actually occurs. Participation in an exercise or roleplay should always be met with the therapist's praise or recognition for practice and improvement. Constructive criticism about the less effective elements of the participants' behavior is always easier for clients to take once they have been told that their participation is appreciated.

Reminder Sheets and Real Life Practice Exercises

At the end of each session, participants are given a *Reminder Sheet* that outlines all the elements of the new skills taught that day. They are also given a *Real Life Practice Exercise* handout (i.e., homework) and are encouraged to reward themselves for successfully completing exercises.

Practice in real life situations is the process by which the content of the session presented in treatment becomes generalized to the client's life outside of treatment. *Reminder Sheet* handouts and *Real Life Practice Exercise* handouts have been designed for each of the seven sessions in this program. *Reminder Sheet* handouts are single sheets that serve to

summarize and highlight the key points made during each session. *Real Life Practice Exercise* handouts require that the participant reflect on or try out a skill that was discussed or roleplayed during a session. The real life practice assignment sometimes requires that the participant record facts about a setting, a chosen behavior, a response to a chosen behavior, or an assessment of outcome.

Compliance with exercises is often a problem in behavioral therapy. In CBT7, no contingencies other than social praise or disapproval are used by the therapists to enhance compliance. Several measures are recommended to help generate compliance:

- Refer to the exercises as "real life practice" to avoid negative connotations associated with the term "homework."
- When giving assignments, provide a careful rationale and description.
- Ask what problems clients can foresee in completing an assignment, and discuss ways to overcome them.
- Ask clients to set aside a specific time in the day to work on the assignment.
- Review exercises from previous sessions at the beginning of each session, and praise compliance efforts.
- For those who did not do an assignment, discuss the benefits of completing assignments and what could be done to ensure compliance the next time.

Session Management

Session Length and Time Management

Group sessions should be kept to their recommended length of 75 minutes. Although sessions may run over or under the allotted time, therapists are responsible for structuring sessions so that deviations are minimal. If time management is a problem, it may be worthwhile for therapists to present a timetable at the start of each session so both they and the participants can monitor the time (Steinberg et al., 1997, page 27).

Preexisting or Concurrent Relationships Between Two Participants

A preexisting relationship between two group members does not automatically justify exclusion of either party. These relationships are to be judged on a case-by-case basis. If a preexisting relationship is disrupting treatment, the therapist should refer the case to a supervisor.

Outside Crises

Because each session has its own agenda, outside crises can be given only limited time at the beginning of sessions. If acute problems arise during the week, participants and their parents can contact therapists at their offices. (In the CYT study, home phone numbers of therapists were not given to participants or parents. However, for the users of this volume, the policy of the facility should be followed.) If a participant or parent calls regarding a serious emergency (i.e., one in which harm is imminent), the therapist should encourage the family to call 911 or go to the nearest emergency room. If someone calls with an acute concern (e.g., continued use), the CBT7 therapist should give the caller an opportunity to air this concern and recommend that the issue be raised in the next group session.

Request for Individual Attention

Individual consultation after a participant has completed individual treatment and joined a group is seldom advisable, unless clinical deterioration is suspected. If a group member wishes to discuss a problem with a therapist privately, the need for consultation should be explored. When appropriate, the therapist should recommend that the participant raise the issue in the group.

Session 6: Problem Solving

Overview

Purpose: To help group members develop problem-solving strategies for handling situations that place them at risk for a "slip" or relapse

Total Time: 75 minutes

Breakdown:
- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice Exercise** (10 minutes)
- **Rationale for Coping Skill: Problem Solving** (15 minutes)
  - ➤ Having problems is normal. Everybody has them.
  - ➤ Solving problems takes time.
  - ➤ The five steps of problem solving are recognizing, identifying, creating options, making a decision, and evaluating.
- **Skill Guidelines** (15 minutes)
  The Five Steps:
  1. Recognize that a problem exists.
  2. Identify the problem.
  3. Come up with possible solutions.
  4. Make a decision and act on it.
  5. Evaluate the outcome of your decision.
- **Group Exercise** (20 minutes)
- **Real Life Practice Exercise** (5 minutes)
  Reminder Sheet for Problem Solving and *Real Life Practice Exercise for Problem Solving*

Materials:
- A *Reminder Sheet for Problem Solving* handout for each group member
- A *Real Life Practice Exercise for Problem Solving* handout for each group member
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A session 6 *Problem Solving* poster (see appendix 1)

PROCEDURES: PROBLEM SOLVING

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week and any current problems with marijuana. Reinforce any coping skills they have successfully used to avoid using marijuana.

Review of Real Life Practice Exercise (10 minutes)

Review the *Personal Emergency Plan* handout, which was distributed in the last MET/CBT5 group session (see Sampl & Kadden, 2001, page 81).

Rationale for Coping Skill: Problem Solving (15 minutes)

> **Therapist Note:** When trying to get teenagers to talk about their problems with marijuana, use open-ended questions and draw on the personalized feedback report (Sampl & Kadden, 2001, appendix 4), which was filled out during the initial assessment, when it may be useful. When teenagers continue to refuse to acknowledge the existence of marijuana problems, therapists may try shifting the discussion away from problems that are a direct result of marijuana use to marijuana's effect on teens' problem-solving ability (e.g., "Substance use provides an easy escape and makes us feel as if we have solved a problem without actually attempting anything.").

Present the following talking points to group participants. Adjust the presentation to the participants' ability to understand the concepts and terms being introduced.

- All of us have problems. Problems are not for the privileged few; they are for everyone on the planet. If you are having problems, it means you are a human being living with many other human beings who sometimes see, think, and feel differently than you. Sometimes it's going to mean that you and another person will have a disagreement or that two people, both of whom you like, will disagree with each other and ask you to agree with both of them at the same time!

- What makes people different is not whether they have problems but how they deal with them. Some people accept problems as a fact of life and try not to be too bothered by them, so they can start working on solving the problems. Some people accept problems, but they think they can't solve their problems. These people have the ability to problem solve; they just do not realize it. Then there are some people who think they *shouldn't* have problems and that there's something weird or abnormal about having them. They feel weird and abnormal even though they're just like everyone else.

- Everyone in this room has a problem with marijuana. You may have problems that involve or do not involve marijuana directly. The problem-solving steps can be used with any kind of problem. But because these steps take time and because you have only so many hours in a day, you probably don't need to use these steps with every problem. Problems such as "What's 4 x 10?" and "What am I going to wear on Saturday?" can be answered in seconds. The problems we will talk about take time and effort to solve and do not have immediate solutions.

- The first rule of problem solving: it takes time. The number of problems a person has in his or her life may have less to do with how smart that person is than how much time that person spends thinking problems through. If you don't stick with problem solving, then problems will stick to you. But if you do stick with it, you will have the privilege of watching problems get smaller and smaller as your confidence grows. If you stick with it long enough, you might even begin to think of problems as challenges.

Explain to the group that solving problems involves five steps.

- **Step #1:** The first step is to accept that the problem *exists* and not get bent out of shape about it. When you get bent out of shape, you are likely to do two things you should never do when making a choice. You either (1) do nothing—which gets you nowhere—or (2) do the first thing that pops into your head—which gets you where you did not plan to be. Instead, you want to go somewhere in particular, and you want to decide carefully where that somewhere should be. So, the first step is to admit that the problem exists and get ready to work.

- **Step #2:** The second step is to identify the problem and flesh it out. Much of what makes a problem threatening is that it is unknown. The relief that we experience when we get to know our problems is the same relief we experience when we get to know someone who was once a stranger. Don't let your problem be a stranger. Notice whether it is similar to problems you've had before. Notice how it is different from other problems, and learn about the differences. Find out what is critical to you about this problem. Most important, notice that what you think about the problem changes the more you learn about it. Soon the problem isn't a stranger. It's familiar and something you can work with.

- **Step #3:** The third step is to come up with solutions. The key here is to forget about getting the right answer. Forget about right answers, and forget about good answers. You're trying to solve your problem; this is not about getting a grade. Come up with a lot of different kinds of solutions. Come up with as many as you can imagine. Come up with at least four or five (and then come up with a hundred more)! Pile one on top of another. Make your solutions simple; make them huge; make them far-fetched! But just keep coming up with them until you have covered at least several pages of paper.

- **Step #4:** The fourth step is decision making. Notice that a lot of other parts of problem solving had to happen before you could even get to this point. Most of us think that decision making is all there is to problem solving. And that is why many of us have problems that keep coming back. But you are not going to make that mistake. You have fleshed out your problems and have come up with a lot of solutions, and now you are ready to pick and

choose (and even *put together*) which solutions you want to use. You want a solution that works and gets you where you want to go. So now is the time to decide which solutions are really *doable* and which of these doable solutions will put you where you want to be.

- **Step #5:** The fifth step is called evaluating, or following up. This is another step, like coming up with solutions, that people tend to forget about. Following up means testing to see whether your decision really worked. Remember, problems exist only because they are problems for you. You are the only one who can decide whether a solution worked. You need to find out what happened when you acted on your decision. Did somebody treat you differently? Did you feel stronger, clearer, more comfortable afterward? Did something happen that you didn't expect?

- After you have found what actually happened in the real world, you can now ask yourself the all-important question: *Did your solution work?* If your answer is "Yes," then it is time to bask in the glory of your genius. If the answer is "Kind of," then maybe your decision needs some tweaking. If your answer is "No," the good news is you came up with other solutions in Step 3, so you have more solutions to try. If you came up with five solutions in Step 3, you have four more to try. And if you came up with 100, you have 99 more chances to reach a solution.

Skill Guidelines (15 minutes)

Explain to group members that they will now have an opportunity to apply the five-step model for solving problems effectively. Use the following information in the presentation.

- **Step #1:** Recognize that a problem exists. First, recognize that a marijuana problem exists. You have received signs that a problem exists from several sources.

  - Your **body** (e.g., you have cravings, are restless)

  - Your **thoughts and feelings** (e.g., you feel angry, anxious, nervous, depressed, lonely)

  - Your **behavior** (you have not met your standards at school, at work; you are concerned about your relationship with your family, with your friends)

  - **Your reactions to other people** (e.g., you are angry, irritable, not interested, withdrawn)

  - **Other people's reactions to you** (e.g., they avoid, criticize you).

- **Step #2:** Identify the problem. Once you identify the problem, clarify it. Gather as much information and as many details as you can. Define the problem in terms of behavior whenever possible. Break it down into parts—you may find it easier to manage parts individually than to confront the whole problem at once.

  - **An example of a problem:** Every time you stay out late on school nights without calling home, your parents get worried and angry and accuse you of smoking pot with friends, even when you haven't.

  - **Examples of some clarifying questions:** Who is affected? How does each one see the situation? What is the outcome that you want to change (e.g., arguing reduced)? What do other people want to see changed? What things have led up to the problem (e.g., your history of pot smoking, past dishonesty about drug use, parents not knowing your whereabouts, parents not trusting you)?

- **Step #3:** Come up with solutions. Brainstorm to generate possible ways to solve a problem. Key guidelines for generating possible solutions are the following:

  - Remember, more is better. Do not judge solutions! (Judging is for later.)

  - Come up with solutions that include both actions and thoughts.

- **Step #4:** Make a decision and act on it. Go through each solution you have come up with, and ask yourself the following questions:

  - What is most likely to happen if I choose this solution?

  - What are the good or bad things that might happen?

  - How likely is it that the good or bad things are going to happen?

  - What will happen immediately after I choose this one?

  - What will happen a long time after I choose this one?

  - How difficult will this option be to carry out?

  Pick one or more possible options. Also, pick options that are most likely to have good outcomes in the short and long term and least likely to have bad outcomes in the short and long term.

- **Step #5:** Evaluate the outcome of your decision. Try out the solution you decided on. The solution may not be immediate, and you may have to wait or keep working at it. As you begin to see the effects of your decision, evaluate strengths and weaknesses by asking yourself the following questions:

  - What problems am I experiencing?
  - Are these the results I expected?
  - Can I do something to make this solution work better?
  - Do I need to consider a different solution?

Group Exercise (20 minutes)

Tell group members it is time to practice the problem-solving model and have them volunteer practice problems using the following guidelines:

- Remind group members to work on the problem recognition and identification stages, with particular emphasis on describing the problem in as much detail as possible.
- Have the group brainstorm solutions, or choices, and write them on the blackboard or posterboard.
- Encourage group members to consider both positive and negative effects and both short- and long-term consequences when weighing alternatives.
- Ask the group to prioritize alternatives and select the most promising one.

Real Life Practice Exercise (5 minutes)

Give group members the *Reminder Sheet for Problem Solving* handout outlining the model and the *Real Life Practice Exercise for Problem Solving* handout to be completed by the next session. Encourage participants to focus on current or recent problems involving marijuana or problems that may have been caused by marijuana use.

SESSION 6

REMINDER SHEET FOR PROBLEM SOLVING

These, in brief, are the steps of the problem-solving model.

- **Recognize that a problem exists. "Is there a problem?"** We get information from our bodies, our thoughts and feelings, our behavior, our reactions to other people, and other people's reactions to us.

- **Identify the problem. "What is the problem?"** Describe the problem the best way you can. Break it down into smaller parts if this is more helpful.

- **Come up with possible solutions. "What can I do?"** Brainstorm to think of as many solutions as you can. Think of solutions that involve your thoughts and your behavior.

- **Make a decision and act on it. "What will happen if . . . ?"** Consider all the positive and negative short- and long-term consequences of each alternative. Choose one option that is likely to solve the problem with the least amount of hassle to you and others.

- **Evaluate the outcome of your decision. "How did it work?"** After you have tried the solution, does it seem to be working? If not, consider what you can do to make the plan work, or give it up and try the next best solution.

Session 6

Real Life Practice Exercise for Problem Solving

Select a problem that you have now (that was not discussed in group) or one that you may have a hard time coping with in the future. Follow the steps of the model. Remember to describe the problem well and brainstorm a list of possible solutions. Think about your choices, then rank them in the order of which solution you think will work best. When you have decided which solution you believe is the best one, try it out; then evaluate how well it worked.

AN EXAMPLE

You are going to a keg party where you know people will be drinking and getting high.

YOUR PROBLEM

1. Recognize that a problem exists.

2. Identify the problem. (Describe what the problem is.)

3. Come up with possible solutions. (Make a list [brainstorm].)

4. Make a decision. (Rank the solutions, and think about the consequences of each.)

5. Evaluate the outcome of your decision. (Consider positive and negative results.)

Session 7: Anger Awareness

Overview

Purpose:

1. To reinforce group members' recognition of external situations that trigger anger and internal reactions that signal anger
2. To introduce group members to relaxation as a technique for coping with anger

Total Time: 75 minutes

Breakdown:

- **Collection of Urinalysis Specimens** (prior to or after session)
- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice Exercise** (10 minutes)
- **Rationale for Coping Skill: Anger Awareness** (5 minutes)
  - Anger is a normal feeling we all have at times.
  - Anger has constructive and destructive effects.
  - There is a relationship between anger and marijuana or alcohol use.
- **Skill Guidelines** (5 minutes)
  - External situations that trigger anger: direct and indirect
  - Internal reactions that signal anger: feelings, physical reactions, sleep problems, helplessness, or sadness
- **Group Exercise** (10 minutes)
- **Activity Sheets** (10 minutes)
  - *Activity Sheet 1: Anger Triggers*
  - *Activity Sheet 2: Conducting a Self-Interview*
- **Real Life Practice Exercise** (5 minutes)
  - *Anger Awareness Reminder Sheet and Real Life Practice Exercise*
- **Rationale for Coping Skill: Relaxation Technique** (10 minutes)
- **Modeling and Group Exercise** (10 minutes)

Materials:

- A drug-test kit for each group member
- *Activity Sheet 1: Anger Triggers* handout for each group member
- *Activity Sheet 2: Conducting a Self-Interview* handout for each group member
- An *Anger Awareness Reminder Sheet and Real Life Practice Exercise* handout for each group member
- A *Real Life Practice Exercise: Relaxation Technique* handout for each group member
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A session 7 *Anger Awareness* poster (see appendix 1)

PROCEDURES: ANGER AWARENESS

Collection of Urinalysis Specimens

> **Therapist Note:** Collect urinalysis specimens at either the beginning or the end of this session depending on the therapist's discretion and group logistics. If a participant is absent, collect a urine specimen at the next session the participant attends. A discussion of urine specimen collection procedures can be found on page 24.

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week. Discuss the participants' attempts to deal with current problems related to marijuana use. Reinforce any coping skills they have used successfully to avoid using.

Review of Real Life Practice Exercise (10 minutes)

Review with participants the *Real Life Practice Exercise for Problem Solving* handout from session 6.

Rationale for Coping Skill: Anger Awareness (5 minutes)

> **Therapist Note:** The message to convey in this session is that anger is both a useful and a potentially destructive emotion. Anger can signal problematic situations and provide energy to solve them. However, group members may be more familiar with destructive responses to anger that include impulsive behavior, communication avoidance, aggressive and violent behavior, and substance use.

Present the following talking points to group participants. Adjust the presentation to the participants' ability to understand the new concepts and terms being introduced.

- Anger is a normal human emotion. There is a distinction between anger as a feeling and the actions we take because of anger. We all experience anger now and then. What makes us different is how we choose to handle our anger.

- Anger can have different effects depending on what we do with it. Sometimes we can use it to assert ourselves or get through an unpleasant task. At other times, we may take it out on something or someone.

  Question: When can anger be used constructively?

  Answer: Anger can energize us to solve problems. For example, if you hear a classmate criticizing a friend, you may be energized to support that friend and to remind classmates of that person's good points. Anger is also

like the yellow light on a traffic signal that tells you to slow down and think about what's important to you. Hearing that friend being criticized may make you think about how much you care about that friend.

Question: When might we use anger destructively?

Answer: Anger is destructive when it prevents you from thinking clearly. Anger can be expressed in ways that may be harmful to you or others, such as an aggressive response. Or it may lead you to stuff your feelings deep inside. This is a passive response. Aggressive responses block communication and create distance between you and others. Passive responses leave you feeling helpless or depressed, make you appear indifferent to other people, and may result in an angry explosion about something unrelated.

- It is important to have a strategy to deal with anger to prevent acting out behaviors that hurt yourself or others. You have a right to feel angry, but you have the responsibility to express anger in ways that are not hurtful to yourself or other people.

- Anger and marijuana or alcohol use are related. Many people report that they get stoned or drunk when they feel angry or upset at another person. And people who are angry and drink or use drugs often get angrier, and sometimes they do things that they wouldn't normally do when sober. Because anger makes it difficult to think straight, sometimes people put themselves in high-risk situations without realizing it.

Skill Guidelines (5 minutes)

Explain that the first step in dealing with anger is to become aware of the feeling. Tell group members that increased awareness can help them identify angry feelings early, before they grow and get out of control.

Remind participants that they have talked several times in the group (during MET/CBT5) about the concept of a trigger. To learn constructive ways to deal with anger, it is helpful to understand what kinds of things trigger anger. Ask members to identify some situations, thoughts, or feelings that make them angry.

Present the following guidelines about increasing awareness of triggers and signals for anger:

1. Become more aware of situations that trigger anger.

- **Direct triggers:** A direct attack on you, whether verbal or nonverbal (e.g., a power play order, a physical attack, an obscene gesture, unfair

treatment), or a circumstance in which you are unable to get something you want

- **Indirect triggers:** Seeing an attack on someone else or being aware of your thoughts and feelings about a situation (e.g., feeling that you are being blamed, thinking that someone is disappointed in you, or feeling that people are expecting too much of you).

2. Become more aware of internal reactions that signal anger. What are some of the signs that you are getting angry?

- **Feelings:** Do you feel frustrated, irritated, annoyed, insulted, or wired? These less intense feelings often happen before you get angry, and you should try to deal with them before they build up and become harder to control.

- **Sleeplessness:** This may be due to angry thoughts and feelings stuffed down during the day or continuing anger about something that happened earlier.

- **Feeling tired, helpless, or depressed:** It may be that your attempts to express anger have not worked in the past, and you may feel frustrated and helpless to change the situation. You may then have given up trying and become depressed.

- **Physical reactions:** Do you experience muscle tension in the jaw, neck, arms, hands; headaches; pounding heart; sweating; rapid breathing; or clenched fists?

Write the following table of the emotional and physical signs of anger on the board for all to see.

EMOTIONAL	PHYSICAL
Frustration Irritation Indifference (to others) Agitation (feeling wired) Helplessness Depression Feeling insulted	Muscle tension in your jaw, neck, arms Headache Pounding heart Rapid breathing Sweating Sleeplessness Impulsive behavior (acting without thinking)

Explain that many of the physical and emotional signs of anger are the same symptoms people experience when they are withdrawing from marijuana. Tell participants that if they have recently stopped smoking marijuana after smoking it for a long time, they may notice that they are experiencing some of these signs and symptoms more often than usual. These are temporary symptoms that usually disappear in a few weeks. Some people are tempted to get high when they experience these problems. However, getting high

again only makes these physical and emotional problems last longer. If participants stay abstinent, most of these symptoms will go away or occur less often. People who have a hard time handling frustration may find these symptoms harder to handle. Because problems with anger can often set off a relapse, it is important to practice coping skills between sessions.

Group Exercise (10 minutes)

Have group members list personal anger triggers and the internal reactions they invoke. Strive for a variety of situations (e.g., at home, at school, at a party) with a variety of people (e.g., family, friends, teachers, strangers). In addition, try to elicit responses on a variety of internal reactions that signal anger (e.g., feeling insulted or helpless, muscle tension, difficulty sleeping).

Activity Sheets (10 minutes)

Have group members complete the activity sheets for *Anger Triggers* and *Conducting a Self-Interview*. Also notify participants that the activity sheet for *Conducting a Self-Interview* will be used again in session 8, so they should bring it to the next session.

Real Life Practice Exercise (5 minutes)

Give the group members the *Anger Awareness Reminder Sheet and Real Life Practice Exercise*, and tell them to complete it before the next group session. Instruct them to pay attention to situations that make them angry, as well as to internal reactions such as the thoughts, feelings, behaviors, and physical signs that signal anger. Again, notify participants that this reminder sheet/real life practice exercise will be used in session 8, so they should be sure to bring it to the next session.

Rationale for Coping Skill: Relaxation Technique (10 minutes)

Therapist Note: Conduct two tension-relaxation cycles for each muscle group. Start with the face and move to the neck, then to the shoulders, arms, stomach, back, and finally the legs. Allow 5 seconds of tension and 15 to 20 seconds of relaxation for each cycle.

In relaxation training, how you say things is as important as what you say. It is not necessary to talk continuously during the tension or relaxation phase. The therapist should begin the session in a conversational tone and become a bit louder and more intense during the 5-second tension instructions. Over the course of the rest of the session, the therapist's voice should show a progressive reduction in volume and speed, becoming calm, soft, and rhythmic. The therapist should model the technique for group members.

Some adolescents may be apprehensive about the eye-closing aspect of the activity because of anxiety that can be due to past abuse or they may feel silly or unsafe about closing their eyes for an extended period. For these adolescents, the therapist should make this part of the activity

optional and instruct them to select a particular point in the room and focus on it during this period. The therapist should explain that the objective of the activity is to help adolescents concentrate on relaxing the muscles in their bodies, not to make them feel anxious or silly.

Each tension-relaxation cycle consists of the following instructions:

- Tense up, hold the tension, and become aware of it (5 seconds).
- Relax and feel the tension flowing out of your body (5 seconds).
- Tune in to the feelings of relaxation, notice the difference between the tension and relaxation, and enjoy the contrast (15 to 20 seconds).

Present the following talking points to the group.

- This part of today's session focuses on the use of relaxation techniques in coping with anger, stress, tension, and anxiety. Being angry and stressed can lead to difficulty concentrating, bad decision making, and a lot of unnecessary arguing. Now that we have discussed how to be aware of anger, we can discuss a way of dealing with it. One way is to relax. At first, you might think it odd that relaxing is something that you do. Most of the time, we think of relaxing as just not doing anything. But just as we sometimes have to be aware of our anger, there are times when we have to actively relax.
- Relaxation is a useful skill. When? Almost anytime. Uses for relaxation include the following: to deal with stressful situations, to deal with everyday stress, to get ready for sleep, to cope with urges to smoke pot, or to think more clearly about a situation or problem.

Modeling and Group Exercise (10 minutes)

Use the following text during the relaxation exercise.

Preparations for Relaxation

- I will guide you through a tension-relaxation exercise, so you can get a good idea of what it involves and can begin to practice it on your own. This exercise is often called progressive relaxation or deep muscle relaxation.
- Progressive relaxation involves taking turns tensing and relaxing different muscle groups to identify feelings of tension and to replace them with feelings of relaxation. We will begin with the face and move to the neck, shoulders, arms, stomach, back, and finally the legs.

- Relaxing is a skill that usually takes practice to master. You will be in control and learn how to relax yourself. It is important that you do not expect too much too soon. You may feel little effect the first few times, although some people feel deeply relaxed the first time.

- I will demonstrate how to tense each muscle group, with you imitating my behavior. I will tense different groups of muscles, for 5 seconds each and then relax each for 15 to 20 seconds.

- Remember:

  - During the tensing phase, don't strain the muscles by tensing them as hard as possible. It is important only that you feel the muscle tensing.

  - After tensing each muscle group, relax those muscles when I say the words, "Relax now."

Relaxation Pretest

- Before we begin, think of a scale from 1 to 10, in which 1 is total relaxation and 10 is maximum tension. Consider where you would place yourself on that scale, and remember it. Write it down on a piece of paper if you need to.

Relaxation Rehearsal

- Now sit back in your chairs. Take a moment to feel the chair against your back, to feel it holding you up. Notice how your back, arms, and legs feel in that chair.

- Now I'm going to count backward from five to one. Close your eyes and gradually let yourself sink into the chair. When I say one, your eyes will be closed: Five. . . four. . . three. . . two. . . one; eyes closed.

- **Tension: 5 seconds.** Remaining in your seats, tense up all the muscles in your face (and subsequent muscle groups: neck, shoulders, arms, stomach, back, and legs). Now hold it. Notice the tension. Hold it, study it, tight, hard, feel the tension in your face (and subsequent muscle groups). Concentrate on how it feels and where it is located.

- **Relaxation: 15 to 20 seconds.** Now relax. Just let go, further and further. Get rid of all the tension. Tune into the feelings of relaxation, deeper and deeper. Just enjoy the feelings in the muscles as they loosen up, smooth out, unwind, and relax, thinking about nothing but the pleasant feelings of relaxation flowing into your face (and subsequent muscle groups). See if you can let it go a little bit more. Even though it seems as if you've let go as much

as you possibly can, there always seems to be that extra bit of relaxation to let all the tension go. Notice what it's like as the muscles become more and more deeply relaxed, calm, and peaceful. There's nothing to do but focus your attention on the pleasant feelings of relaxation flowing into your face (and subsequent muscle groups). Notice the difference between the feelings of tension and relaxation.

Relaxation Posttest

- Think of a scale from 1 to 10, in which 1 is total relaxation and 10 is maximum tension. Consider where you would place yourself on that scale, and remember it so you can jot it down after you've opened your eyes.

- Now I'm going to count backward from five to one. With each number you are to become more and more fully awake. When I say one, you'll be wide awake, still feeling very comfortable and relaxed, but fully awake and alert: five. . . four. . . three. . . two. . . one; eyes open wide and awake.

Therapist Note:

- Have group members discuss any changes in the level of stress they are experiencing after the exercise compared with their previous tension rating.

- Provide the group with positive feedback for doing well on the exercise (regardless of whether subjective ratings of tension decreased from before or after the exercise).

- Respond to any questions or comments by group members about the relaxation exercise.

- Give group members the *Real Life Practice Exercise: Relaxation Technique*.

Session 7
Activity Sheet 1: Anger Triggers

(Adapted from Auerbach, 1997, page 121)

WHICH OF THE FOLLOWING EVENTS, FEELINGS, AND THOUGHTS ARE ANGER TRIGGERS FOR YOU?

Place one checkmark next to items that *sometimes* trigger your anger. Place two checkmarks next to items that make you angry *most of the time*.

_____Being told what to do

_____Being treated in a way you think is unfair

_____Being blamed for something you did wrong

_____Being blamed for something you didn't do

_____Having someone criticize you

_____Finding out that someone said something mean about you when you weren't there

_____Being asked to do more things than you can handle

_____Seeing someone have something that you don't have and that you want

_____Thinking that someone you care about is angry or upset with you

_____Having to stop doing something that you enjoy

_____Not having things happen the way you wanted them to happen

Session 7

Activity Sheet 2: Conducting a Self-Interview

(Adapted from Auerbach, 1997, page 123)

Once you've calmed yourself down after being angry, it is time to take a close look at the situation you are in. Some helpful images to keep in mind are a camcorder and a VCR.

First, imagine that a camcorder recorded the whole situation from start to finish. You are one of the actors in the video. Second, take the tape out of the camcorder and put it in the VCR. Now press rewind, or run an instant replay, and watch what happened again. This will give you a chance to review what happened as many times as you want, to get a better understanding of what occurred. Your goal is to see clearly what has happened, now that you are cooled down and are in control.

Conduct a self-interview. You need to try to be openminded to do this exercise well. Imagine you are a reporter on the scene. Try interviewing yourself (the actor in the video) to get a better idea of what happened, how you reacted, and what you should do next. Try to get just the facts. Ask yourself the following questions:

1. What's getting me angry? What was the TRIGGER?
2. What is my anger rating?

Not Angry Rage

3. What exactly did the people involved say or do?
4. What kinds of different things could they have meant?
5. Is this a personal attack or insult?
6. Are my assumptions about this situation correct?
7. Am I angry because I'm expecting too much of myself or of someone else?
8. Is someone trying to get me angry?
9. What are the positives in this situation?

Session 7

Anger Awareness Reminder Sheet and Real Life Practice Exercise

Anger is a normal human emotion. Being aware of anger can help you use it in a constructive way. Until the next session, pay attention to external situations that make you angry, and identify the anger triggers. Also, try to recognize internal reactions that signal anger, and identify what these are. Then pick one instance of anger before the next session, and put checkmarks by the external events and by the internal reactions that led to your anger.

Direct Triggers

External Events That Trigger Anger (✔ *Check*)

Direct attack on you (verbal or nonverbal):

Physical attack _____
Unfair treatment _____
Bossy treatment (being told what to do) _____
Blame _____
Criticism _____
Mean statements behind your back _____

Circumstance in which:

You are unable to get something you want _____
Someone else has something that you don't have, but that you want _____
You have to stop doing something you enjoy _____
Things don't happen the way you wanted them to happen _____
You are unable to reach a goal _____

(continued on next page)

Indirect Triggers

Seeing someone else attacked in some way _____
Being aware of your thoughts and feelings about a situation _____
Feeling that too much is being expected of you _____
Feeling that you are being blamed _____
Feeling that you are being criticized _____
Thinking that someone is disappointed, angry, or upset with you (especially someone you care about) _____

Internal Reactions That Signal Anger (✔ *Check*)

Emotions

Feeling frustrated, annoyed, irritated, agitated (feeling wired), insulted _____
Feeling tired, helpless, depressed, indifferent (to other people) _____

Physical Reactions

Muscle tension in different parts of the body (jaw, neck, shoulders, arms, hands, stomach, back, legs) _____
Headache, pounding heart, sweating, rapid breathing, clenched fist _____
Difficulty falling asleep _____
Impulsive behavior (acting without thinking) _____

Session 7

Real Life Practice Exercise: Relaxation Technique

Deep Muscle and Progressive Relaxation Techniques

1. Select a quiet time when you will not be interrupted. Practice at least three times during the next week.

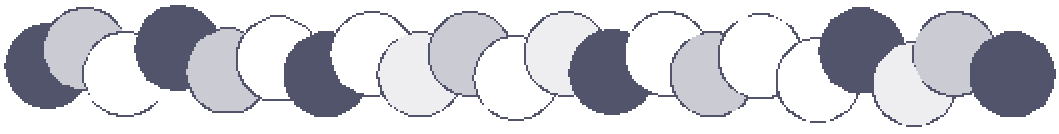
2. Sit in a chair and settle back as comfortably as you can. Take a deep breath and exhale slowly. You may feel most comfortable if you close your eyes. Notice the feelings in your body; you will soon be able to control these feelings.

3. Go through the seven groups of muscles in the directions below, first tensing each muscle group for 5 seconds and then relaxing each for 15 to 20 seconds.

    - Wrinkle up your forehead. Then relax your muscles.
    - Close your eyes tightly. Then relax your eyes.
    - Clench your jaw, gritting your teeth together. Then relax.
    - Shrug your shoulders toward your head. Tilt your chin toward your chest. Then relax.
    - Flex both arms at the elbows. Then relax your arms.
    - Squeeze both hands into fists, with your arms straight. Then relax your hands.
    - Stretch out both legs, point your toes toward your head, and press your legs together. Then relax your legs.

4. Before each practice exercise, rate your level of relaxation and tension. Using a scale of 1 to 10, with 1 being very relaxed and 10 being very tense, rate how your body feels after completing each practice exercise.

Rating (1–10) before practice exercise	Rating (1–10) after practice exercise
_____	_____
_____	_____
_____	_____



Session 8: Anger Management

Overview

Purpose: To teach healthy coping skills for dealing with anger

Total Time: 75 minutes

Breakdown:

- **Discussion of Urinalysis Results With Individual Group Members** (prior to group)
- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice Exercise** (10 minutes)
- **Rationale for Coping Skill: Anger Management** (15 minutes)
  - ➤ Review triggers from session 7
  - ➤ Present Model of Anger: Events ➞ Thoughts ➞ Feelings
- **Skill Guidelines** (15 minutes)
  The Four Steps:
  1. Chill Out: Successful past strategies and self-statements
  2. Collect Your Thoughts: Self-interview, anger triggers, options, and problem solving
  3. Choose the Best Action: Decide and evaluate outcome
  4. Change the Way You Think About Anger
- **Group Exercise** (15 minutes)
- **Real Life Practice Exercise** (10 minutes)
  Reminder Sheet for Anger Management and *Real Life Practice Exercise for Anger Management*

Materials:

- A *Reminder Sheet for Anger Management* handout for each group member
- *A Real Life Practice Exercise for Anger Management* handout for each group member
- Session 7 handouts for each group member: *Activity Sheet 2: Conducting a Self-Interview* and *Anger Awareness Reminder Sheet and Real Life Practice Exercise*
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A session 8 *Anger Management* poster (see appendix 1)

PROCEDURES: ANGER MANAGEMENT

Discussion of Urinalysis Results

Therapist Note: The results of the urinalysis specimens obtained in the previous session should be discussed with participants before the group session. If a participant failed to attend the previous group, obtain a urine specimen during this group session and review the results before the next session. Guidelines for the presentation of urinalysis results can be found on page 24.

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week. Discuss the participants' attempts to deal with current problems related to marijuana use. Reinforce any coping skills they have used successfully to avoid using marijuana.

Review of Real Life Practice Exercise (10 minutes)

Review the *Anger Awareness Sheet and Real Life Practice Exercise* assigned in session 7, Anger Awareness.

Rationale for Coping Skills: Anger Management (15 minutes)

Present the following talking points to participants. Adjust the presentation to the participants' ability to understand the concepts and terms being introduced.

- The last session was devoted to anger awareness and to recognizing events that trigger anger. (See *Anger Awareness Reminder Sheet and Real Life Practice Exercise* handout from session 7.) This session focuses on techniques for managing anger. Anger is not automatically triggered by events. Our thoughts and beliefs about events play an important part in how we react to a situation. Consider this example. (Write the example below on the blackboard).

Event	→	Thoughts	→	Feelings
Your mother is quiet when you get home.		"I must have done something wrong. She's mad at me again, and we're in for a fight."		Apprehension, anxiety, fear, dread

- What other ways might you have thought about this event? How might these different thoughts have led to different feelings?

Skill Guidelines (15 minutes)

Explain that there are four important steps to help deal with situations that make you angry. Write the steps on the board or ask a participant to do so.

Step #1	Chill out.
Step #2	Collect your thoughts.
Step #3	Choose the best action.
Step #4	Change the way you think.

Use the following presentation to explain each step.

Step #1: Chill out. The first thing to do when you realize you're angry is to try to calm down. How you think changes how you feel about events. But you can't make good decisions if you don't stop and think. Here are some ways to calm down: count to 20, leave the room, close your eyes, or go for a walk. (Encourage participants to share their ideas.) Another way to chill out is to think cool thoughts. (Ask participants to compare cool and hot thoughts. See examples below.)

COOL THOUGHTS	HOT THOUGHTS
Slow down. Take it easy. Take a deep breath. Cool it. Chill out. Relax. Ignore it. Count backward from 20.	It's not fair! I hate when this happens! Why me?! What a jerk! No one cares about me! I give up! This is stupid! It's all my fault!

Step #2: Collect your thoughts. Once you've cooled down, take a closer look at the situation. (Review *Activity Sheet 2: Conducting a Self-Interview* from session 7.)

Step #3: Choose the best action. Once you have a better understanding of what's making you angry, look at your choices. What are some skills you have learned in our sessions that can help you make better decisions when you are angry? (Invite discussion about problem-solving techniques from session 6, such as brainstorming solutions, choosing an option, and evaluating the outcome of one's decision.)

Step #4: Change the way you think about your anger. Think thoughts such as:

- "I am still angry, but anger isn't so awful! After all, I will feel better soon."
- "I can't waste my time being angry about things I can't control right now. It's better to spend time on things I can change. I'm going to get my mind off this."

Group Exercise (15 minutes)

Present the following scenario: A friend of yours took one of your CDs without permission. When you asked him or her to give it back, he or she denied having taken it. You decide to confront your friend.

Appropriately respond to this situation using the four-step model of chill out, collect your thoughts, choose the best action, and change the way you think. Guide the group to generate positive thoughts about situations they wrote about in session 7 for the *Anger Awareness Reminder Sheet and Real Life Practice Exercise*. When appropriate, have participants roleplay the

situations and think aloud. Ask volunteers to roleplay different situations that require the use of anger management techniques.

Real Life Practice Exercise (10 minutes)

Give the group members the *Reminder Sheet for Anger Management* and *Real Life Practice Exercise for Anger Management* to be completed before the next session. This exercise involves identifying a situation and the thoughts that provoked anger and then trying to change the reaction.

Session 8

Reminder Sheet for Anger Management

Anger can result from the way we think about things:

Events ➞ Thoughts ➞ Feelings

There are four important steps to help deal with situations that make you angry.

Step #1: Chill Out

Use phrases like these to help you calm down:

Slow down.	Chill out.
Take it easy.	Easy does it.
Take a deep breath.	Relax.
Cool it.	Count backward from 20.

Step #2: Collect Your Thoughts

Next, think about what's getting you so angry. Review the situation point by point.

- What's getting me angry?
- Is this a personal attack or insult?
- Am I expecting too much of myself or of someone else?

Step #3: Choose the Best Action

Then think about your options.

- Anger should be a signal to start problem solving.
- What can I do?
- What is in my best interests here?
- What other coping skills may be helpful here?

Step #4: Change the Way You Think About Anger

If the problem won't go away,

- Remember that you can't fix everything.
- Try to shake it off.
- Don't let it interfere with your life.

If you solve the problem, congratulate yourself!

Session 8
Real Life Practice Exercise for Anger Management

Until the next session, pay attention to your reactions to situations that make you angry. Try to identify the thoughts that are making you angry and try to change them. Before the next session, pick one occasion involving angry feelings (or feelings of annoyance, frustration, or irritation) and write down the following:

Trigger situation:

Calm-down phrases used:

Anger-increasing thoughts:

Anger-reducing thoughts:

What other thoughts might have helped you cope with this situation?

Session 9: Effective Communication

Overview

Purpose: To teach effective communication through active listening, assertiveness, and strategies for responding to criticism

Total Time: 75 minutes

Breakdown:

- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice Exercise** (10 minutes)
- **Rationale for Coping Skill 1: Active Listening** (5 minutes)
  The Four Steps:
  1. Listen
  2. Rephrase
  3. Ask questions
  4. Show you understand
- **Rationale for Coping Skill 2: Assertiveness** (10 minutes)
  The Four Types of People:
  1. Passive
  2. Aggressive
  3. Passive-aggressive
  4. Assertive
- **Skill Guidelines** (5 minutes)
- **Group Exercise #1** (5 minutes)
- **Rationale for Coping Skill 3: Receiving Criticism** (10 minutes)
  - ➤ The Two Types of Criticism
    1. Constructive
    2. Destructive
  - ➤ Relationship between receiving criticism and marijuana use
- **Skill Guidelines** (5 minutes)
  1. Don't get defensive, don't argue, and don't counterattack
  2. Ask for clarification
  3. Find something in the criticism with which you agree
  4. Propose a compromise
  5. Reject unfair criticism
- **Group Exercise #2** (10 minutes)
- **Real Life Practice Exercises** (5 minutes)

Materials:

- A *Reminder Sheet for Receiving Criticism* handout for each group member
- A *Real Life Practice Exercises for Receiving Criticism—Exercises 1 and 2* handout for each group member
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A session 9 *Effective Communication and Receiving Criticism* poster (see appendix 1)

PROCEDURES: EFFECTIVE COMMUNICATION

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week. Discuss the participants' attempts to deal with current problems related to marijuana use. Reinforce any coping skills they have used successfully to avoid using marijuana.

Review of Real Life Practice Exercise (10 minutes)

Review the *Real Life Practice Exercise for Anger Management* handout assigned in session 8.

Rationale for Coping Skill 1: Active Listening (5 minutes)

Present the following talking points to the participants. Adjust the presentation to the participants' ability to understand the concepts and terms being introduced.

- The first thought that comes to mind when we think of communication is of someone talking. However, talking is only half of communicating; the other half is listening. We sometimes forget about listening, the silent partner of talking. But we do know when listening is not occurring. Without listening, people do not communicate.

- Even though we pay less attention to listening, we are attracted to people who listen. The active listener tells us that we are being paid attention to and that what we are saying is being heard. Here are four steps for active listening. (Write the four steps on the board.)

> Active Listening
> 1. Listen.
> 2. Rephrase.
> 3. Ask questions.
> 4. Show that you understand.

- **Step #1:** Listen. Pay attention to people when they talk to you. Repeat their words to yourself. If, after repeating their words in your head, you find something that you don't understand, remind yourself to ask a question later.

- **Step #2:** Rephrase. To rephrase is to restate out loud what people are saying to you. This might sound weird, but you will be surprised how many people appreciate it. Rephrasing is the most direct way of showing someone that you are paying attention. (The therapist may wish to demonstrate this skill to the group.)

Rephrasing

1. It seems as if you feel. . . .
2. It sounds as if you are. . . .
3. If I am hearing you right, you're feeling. . . .
4. So you're feeling like. . . .
5. So you're saying that. . . .

- **Step #3:** Ask questions. Asking questions shows other people that you are paying attention to what they are saying and that you want to hear more.

- **Step #4:** Show that you understand. There are many different ways to show that you understand what someone is trying communicate to you: rephrasing, summarizing, or even admitting that you don't understand everything he or she is saying. Saying you don't understand everything shows that you do understand some of it. Showing someone you understand is not the same thing as saying that you agree with him or her. You can have a different point of view from someone else but still understand his or her point of view.

Rationale for Coping Skill 2: Assertiveness (10 minutes)

Discuss the following talking points with group members:

- Assertiveness means expressing your opinion without hurting other people, asking other people to change their behavior, or rejecting what other people say. The trick is to say what you mean, while letting others know that you respect what they have to say. By asserting yourself, you can get your needs expressed without being passive, aggressive, or passive-aggressive.

- There are four ways of getting along with others: passive, aggressive, passive-aggressive, and assertive. (See session 5 of the MET/CBT5 manual [Sampl & Kadden, 2001].)

  - **Passive** people tend to give up their rights as soon as they get into a conflict with someone else. They don't stand up for themselves, and they let other people walk all over them. They don't let others know what they are thinking or feeling. They bottle up their feelings, even when they don't have to, and feel anxious or angry inside a lot of the time.

  - **Aggressive** people protect their own rights but run over other people's rights. They may actually satisfy their own short-term needs, but their behavior harms their relationships with other people who, in the long run, may resent the way they have been treated.

  - **Passive-aggressive** people are indirect. They hint at what they want, make sarcastic comments, or mumble something,

without saying what is really on their minds. They won't say how they feel, but they will "act it out." For example, they will slam doors, give someone the "silent treatment," be late, or do a sloppy job.

- **Assertive** people decide what they want, plan an appropriate way to involve other people, and then act on the plan. They state their feelings or opinions clearly and are specific about what they want from others. They stand up for themselves and do not fall back on threats, demands, or negative statements to get what they want.

Skill Guidelines (5 minutes)

Explain to the group that the following points are useful to remember when practicing assertiveness:

- Think before you speak.
- Be specific and direct in what you say.
- Pay attention to your body language. Use eye contact; face the person you're talking to.
- Be ready to compromise. Think about what behaviors you are willing to change to get what you want.
- Repeat or rephrase statements if you think you're not being heard.

Group Exercise #1 (5 minutes)

Ask a participant to roleplay and take the part of a friend at school who suggests they should smoke a joint in the rest room during lunch period. The therapist models passive, aggressive, passive-aggressive, and assertive responses. After each type of response, ask participants from the whole group to identify the type of behavior being demonstrated and whether it was successful.

Have participants generate situations they found difficult in the past and roleplay assertive responses to those situations. The situations do not have to relate to marijuana use.

Rationale for Coping Skill 3: Receiving Criticism (10 minutes)

Tell participants that criticism is a part of life. It provides everyone with a chance to learn more about themselves and about how they affect other people. Remind participants that everyone has room for improvement. Listening to and hearing criticism can be hard, but it has its rewards. Other people grow to respect that we are ready to hear their point of view. This also helps us avoid conflicts.

Explain that there are two types of criticism:

1. **Constructive** (or assertive) criticism is about what a person does and not about who a person is. This kind of criticism asks for real changes, because people can change what they do but not who they are.

2. **Destructive** (or aggressive) criticism is about who a person is. Destructive criticism is not really looking for a change but is attempting to hurt someone or start a fight.

Explain further that constructive criticism can help participants if they can hear it. It provides a chance to change. Destructive criticism is not worth worrying about. Sometimes, someone may be feeling bad and taking it out on another person. Tell participants that when they hear destructive criticism, it is better just to walk away.

Describe how learning to accept criticism can help participants resist using marijuana. Learning to accept criticism helps things go more smoothly with other people. If participants are feeling better about getting along with other people, they don't need marijuana to feel better. Explain that some participants may have been criticized for using marijuana. If they pay attention to the part of that criticism that is "constructive," they can get some useful information about how to change. Tell the group members not to worry if the criticism doesn't stop when they stop using marijuana. It takes time for people to begin trusting them again. Others may still be thinking about their smoking behavior. It takes time for others to notice the good effort they are making today.

Skill Guidelines (5 minutes)

Explain the following five points about receiving and responding to criticism.

1. **Don't get defensive, don't argue, and don't try to get back at people (counterattack).** Doing these things will only make the situation worse and give you less chance of talking things out.

   Consider the following example: A teenager heading out for a rock concert is criticized by his or her parent for going to the concert. The teenager replies, "What do you know about my music? You're clueless." This kind of statement may be offensive and directs attention away from the feelings leading to the argument.

2. **Check in with the other person so that you really understand what that person is criticizing.** This gives you a chance to find out what the person is really worried or angry about. Then you will be in a better position to know whether the criticism is constructive (there's something I can change here) or destructive (this person is just trying to get at me and I am going to ignore it).

To continue with this example: A nondefensive reply, and one that would help someone understand the criticism, would be: "I don't understand why my going to the concert makes you upset. Could you tell me what you're upset about?"

3. **Always look for something in the criticism that you can agree with, and let the person know you agree with it.** Sometimes, criticism is correct. Even if you feel angry, admitting that you made a mistake can help.

   To continue with the previous example: The person going to the concert might say, "You're right, some kids do drugs at concerts, but I don't do that anymore." This approach takes away some of the tension and gives you and the other person time to think.

4. **Propose a compromise.** A compromise means meeting somebody halfway. Suggest something specific you can do to make a change.

   To continue with the previous example: A possible compromise might be that the person going to the concert goes with friends who do not drink or do drugs.

5. **Reject unfair criticism.** Sometimes, criticism is not fair. At these times, it's good to be assertive and reject the criticism firmly and politely. Do not insult the other person. Just let him or her know you do not agree.

   Consider the following example: The lead scorer on a soccer team misses a shot and is criticized by the coach. "You always choke," he says. A good way to respond here is to reject the destructive criticism, look for something to agree on, and make a compromise: "You're right, I missed that shot. I gotta practice it. Maybe if I stay after practice, you'll show me how to nail it. What do you say?"

Group Exercise #2 (10 minutes)

Give group members a chance to roleplay responses to both constructive and destructive criticism. Scenes should involve recent instances of criticism or future situations where criticism is likely to take place. Participants may need some help verbalizing criticisms with enough detail to make the roleplay substantive. Roleplays should include different types of people (e.g., parents, siblings, friends) and different types of criticism (constructive or destructive; accurate or unfounded) and should refer to both recent and past marijuana use.

Real Life Practice Exercise (5 minutes)

Give the group members the *Reminder Sheet for Receiving Criticism* and *Real Life Practice Exercises for Receiving Criticism* to complete before the next session.

Session 9
Reminder Sheet for Receiving Criticism

When you receive criticism, remember the following:

- Don't get defensive.
- Don't argue.
- Don't counterattack.
- Ask questions to get a better understanding of the criticism.
- Find something to agree with about the criticism.
- Propose a compromise.
- Reject unfair criticism.

Session 9

Real Life Practice Exercises for Receiving Criticism

Exercise 1: Responding to Criticism

Stay alert until our next session for any criticism you may receive. Try to respond according to the guidelines outlined in today's session. For one criticism that you receive this week, write down the following:

Describe the situation:

_____

_____

_____

Describe your response:

_____

_____

_____

Communication Checklist	YES	NO
1. Did you behave as if the criticism was nothing to get upset about?	____	____
2. Did you ask questions to understand the criticism better?	____	____
3. Did you find something to agree with in the criticism?	____	____
4. Did you propose a compromise?	____	____

Exercise 2: Responding Assertively

Imagine the following situation: You come home late from a friend's house. You've been drug free for about 3 months. However, your eyes are red, and you're feeling somewhat down and irritable. Your parent (or someone you live with) approaches you and says, "You've been out smoking pot again, haven't you?"

In the space below, write an assertive response:

_____

_____

_____

_____

Session 10: Coping With Cravings and Urges To Use Marijuana

Overview

Purpose: To help group members identify triggers for marijuana use and plan for dealing with social pressure, cravings, and urges to smoke

Total Time: 75 minutes

Breakdown:

- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice** (10 minutes)
- **Rationale for Coping Skill: Coping With Cravings and Urges To Use Marijuana** (15 minutes)
  - Craving is a common experience and may last a long time after group members stop using marijuana.
  - Urges or cravings can be triggered by things in the environment or by certain situations.
  - Cravings and urges are time limited.
- **Skill Guidelines** (15 minutes)
  - Avoid urge triggers
  - Cope with urge triggers you cannot avoid
  - Remember the benefits of abstinence and the negative results of use
- **Group Exercises** (20 minutes)
  - *Activity Sheet for Coping With Cravings*—Craving Triggers, Craving Plan
  - Reminder card: Benefits of abstinence and consequences of use
- **Real Life Practice Exercises** (5 minutes)

Materials:

- An *Activity Sheet for Coping With Cravings* handout for each group member
- A *Reminder Sheet for Coping With Cravings and Urges* handout for each group member
- A *Learning New Coping Strategies* handout for each group member
- A *Real Life Practice Exercise for Coping With Cravings* handout for each group member
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A package of index cards
- A session 10 *Coping With Urges and Cravings To Use Marijuana* poster (see appendix 1)

PROCEDURES: COPING WITH CRAVINGS AND URGES TO USE MARIJUANA

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week. Discuss the participants' attempts to deal with current problems related to marijuana use. Reinforce any coping skills they have used successfully to avoid getting high.

Review of Real Life Practice Exercise (10 minutes)

Review the *Real Life Practice Exercises for Receiving Criticism* handout assigned in session 9.

Rationale for Coping Skill: Coping With Cravings and Urges To Use Marijuana (15 minutes)

Present the following talking points to group participants. Adjust the presentation to the participants' ability to understand the concepts and terms being introduced.

- Cravings are common and most often happen early in treatment. They can keep coming back for weeks, months, and occasionally years after someone stops using marijuana. Cravings may be uncomfortable, but they do not *necessarily* mean that your body or brain is damaged. You do not need to feel ashamed about them. You should expect cravings to happen and be ready to cope with them.

- An urge, need, or craving to use marijuana can be triggered by things you see around you or by situations that remind you of using marijuana. Physical cravings include tightness in your stomach or feeling nervous. Psychological cravings might include thoughts of how good it would feel to smoke pot, memories of when you got high in the past, thoughts about how to get a joint, or just a desire for it. Be alert to people, places, and things that remind you of getting high.

- Craving and urges do not last forever. Usually, they come and go fairly quickly. They ordinarily last only a few minutes or a few hours at most. They do not grow until they are unbearable. They usually peak after a few minutes and then die down—like an ocean wave. As you stay clean, it will become easier to cope with cravings and urges to smoke marijuana.

Skill Guidelines (15 minutes)

Discuss the following talking points with participants:

- Learn how to recognize triggers so you can avoid them or deal with them, so you don't use. There are two kinds of triggers:

those that come from the outside (that is, external triggers) and those that come from the inside (that is, internal triggers).

- External triggers include being in the presence of marijuana, alcohol, or drugs; being around other people who are getting high, drinking, or using drugs; being around people with whom you used to use marijuana; being in places where you used to get high; and times of the day when you used to smoke marijuana. The easiest way to deal with external triggers is to avoid them (e.g., get rid of marijuana in the house or in your car; do not go to parties where drugs will be around; have less contact with friends who smoke pot, drink, or use other drugs).

- Internal triggers include feelings like anger, frustration, and depression. Even positive feelings, such as excitement, feeling "awesome," or the desire to celebrate an accomplishment, can psyche you up for using. Here are four ways to deal with internal cravings and urges:

  - **Distract yourself.** Listen to music, call a friend, go to a movie, or get some exercise, such as bike riding or roller blading. Once you are busy doing something else, the urge will be easier to handle.

  - **Talk it through.** Tell a friend or family member about a craving when it occurs. You may need to educate or remind the person that craving is a normal part of giving up marijuana and that it does not mean you are going to slip back into using. Sometimes it helps to talk to someone else who has quit smoking pot, because that person understands what you are going through and can suggest a helpful alternative.

  - **Challenge and change your thoughts.** When experiencing a craving, people tend to remember only good times connected with marijuana use and often forget the not-so-good times. Remind yourself of the bad things connected with marijuana use and the good things about not using. If it helps, write down the bad things about using and good things about abstinence on a card and carry it with you.

  - **Use "self-talk" to challenge urges.** Self-talk has two steps. First, pretend that the urge can talk to you. Turn that urge into a statement. For example, "I'm really angry; if I don't get high, I'm going to lose it." Second, pretend you are talking to the urge and turn what you are saying into a statement. Repeat to yourself: "Yeah, I'm angry, but getting high isn't going to change the situation. I haven't dealt with anger without getting high for a long time. But I'm going to have to learn to deal with anger differently to stay clean." This may not make the craving completely disappear, but it will make you feel better and more in control of dealing with the urge.

Group Exercises (20 minutes)

Have participants complete the first part (Craving Triggers) of the *Activity Sheet for Coping With Cravings* handout. Ask them to list craving triggers that come from both situations and emotions. Have them circle those they can avoid or stay away from.

Have participants complete the second part (Craving Plan) of the activity sheet. Ask them to list distractions and people they can talk to who will help them cope with their cravings. Have them pick out two or three of the ways that will help them most to deal with cravings and urges.

Show participants the Cravings Log on the *Real Life Practice for Coping With Cravings* handout. Explain how they can use it to keep a journal, or log, of cravings and their efforts to deal with these cravings. Note that the heading for "Intensity" includes a scale that ranges from low (1) to medium (5) to high (10). Also point out that they will be using the cravings log during the next week in the real life practice exercise.

Give each participant a small card and writing materials. On one side of the card, have members write down the benefits of not using marijuana. On the other side, have them write down the negative consequences of marijuana use.

Real Life Practice Exercise (5 minutes)

Distribute the *Reminder Sheet for Coping With Cravings and Urges* and *Learning New Coping Strategies* handouts. Encourage participants to identify strategies they have used successfully in the past, as well as those they are willing to try. Briefly cover major categories in the reminder sheet, and ask participants to review them between sessions.

Give group members the *Real Life Practice Exercise for Coping With Cravings*, and ask them to complete it before the next group session.

Session 10
Activity Sheet for Coping With Cravings

Craving Triggers

Situations that have triggered cravings for me:

1._____

2._____

3._____

Emotions that have triggered cravings for me:

1._____

2._____

3._____

Craving Plan

Distractions that will help me cope with cravings:

1._____

2._____

3._____

People to whom I can talk about my cravings:

1._____

2._____

3._____

Session 10

Reminder Sheet for Coping With Cravings and Urges

Reminders About Cravings and Urges

- Cravings are common and most often happen soon after you quit. But episodes of craving may continue for a long time after you stop using. You should expect cravings to happen and be prepared to cope with them.
- An urge or craving to use marijuana can be triggered by people, places, and things that remind you of getting high.
- Cravings and urges are time limited; they usually peak after a few minutes and then die down, like a wave. Urges will become less frequent and less intense with time.
- Learn how to recognize triggers so you can avoid them.
- Self-monitoring can help you recognize triggers.
- The easiest way to deal with cravings and urges is to try to avoid them.
- Sometimes cravings cannot be avoided, and you have to cope with them.
- Strategies for coping with cravings.
  - Get involved in some distracting activity.
  - Challenge and change your thoughts.
  - Talk it through.
  - Use self-talk to challenge urges.
- Self-talk can strengthen or weaken your urges.
  - Be aware of statements that feed into the urge (i.e., make the urge more intense).
  - Use self-talk constructively to challenge or counterattack those statements.
- Initially, it may seem easier if you replace the urges with distracting activities.

Session 10

Learning New Coping Strategies
A List of Alternatives to Marijuana Use

Below is a list of ways to resist smoking marijuana. From this list, choose ways that you think will work best for you. Expect that you will have to try out some different strategies before you find the ones that work best for you.

Actions

- Avoid or escape from the situation.
- Put off deciding to get high for 30 minutes.
- Do something distracting.

Thoughts

- Give yourself a pep talk.
- Remind yourself of your reasons for quitting.
- Visualize yourself as a nonsmoker—happy, healthy, and in control of your life.
- Picture the long-term effects on your body of smoking marijuana.
- Tell yourself loudly and sharply, "STOP!" then get up and do something else.

Lifestyle

- Exercise regularly.
- Practice relaxation or meditation.
- Take up a new hobby or try an old one.
- Do fun stuff.
- Reward yourself for quitting marijuana.
- Remove all smoking paraphernalia (rolling papers, pipes, bongs, etc.) from your room, car, and home.
- Spend time in places where it's difficult to get high.
- Spend time with friends who don't smoke.

Session 10

Real Life Practice for Coping With Cravings

CRAVINGS LOG

For the next week, complete the cravings log whenever you have an urge to get high.

Date/Time	Trigger	Description	Intensity (1–10)	How Long Urge Lasted	Coping Skills Used/Comments

Intensity of Cravings

Session 11: Depression Management

Overview

Purpose: To teach techniques for being aware of depression and for managing it by identifying and responding to negative thoughts

Total Time: 75 minutes

Breakdown:

- **Collection of Urinalysis Specimens** (prior to or after session)
- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice** (10 minutes)
- **Rationale for Coping Skill: Depression Management** (10 minutes)
  - ➤ Principle: Coping with depression = avoiding relapse
  - ➤ Model of Depression: Events → Thoughts → Feelings
  - ➤ Examples of Coping Skills: Managing negative thoughts, solving problems, and increasing pleasant activities
- **Skill Guidelines** (15 minutes)
  The three A's:
  1. [*Become*] *Aware* of body signs, mood changes, and feelings
  2. *Answer* negative thoughts
  3. *Act* differently
- **Activity Sheet** (10 minutes)
- **Group Exercise** (15 minutes)
- **Real Life Practice Exercise** (5 minutes)
  Reminder Sheet for Depression Management, Reminder Sheet for Thinking Errors, and *Real Life Practice Exercise for Managing Depression and Negative Thoughts*

Materials:

- An *Activity Sheet for Thoughts* handout for each group member
- A *Reminder Sheet for Depression Management* handout for each group member
- A *Reminder Sheet for Thinking Errors* handout for each group member
- A *Real Life Practice Exercise for Managing Depression and Negative Thought* handout for each group member
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A session 11 *Depression Management* poster (see appendix 1)

PROCEDURES: DEPRESSION MANAGEMENT

Therapist Note: This intervention is not sufficient for treating clinical depression. The material covered in this session is designed to reinforce connections among thoughts, feelings, and actions with respect to negative moods and depression. Participants exhibiting signs of major depression should be referred for further assessment and proper treatment.

Collection of Urinalysis Specimens

> **Therapist Note:** Urinalysis specimens should be collected at the beginning or the end of the session, depending on the therapist's discretion and group logistics. If a participant is absent, obtain a urine specimen at the next group he or she attends.

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week. Discuss participants' attempts to deal with current problems related to marijuana use. Reinforce any coping skills they have used successfully to avoid using marijuana.

Review of Real Life Practice Exercise (10 minutes)

Review the *Real Life Practice Exercise for Coping With Cravings* handout assigned in session 10.

Rationale for Coping Skill: Depression Management (10 minutes)

Present the following talking points to group participants. Adjust the presentation to the participants' ability to understand the concepts and terms being introduced.

- The goal of this session is to learn to use cognitive behavioral techniques for dealing with mild and moderate depression and negative moods. According to cognitive behavioral theory, these moods can be partially alleviated by changing how one thinks and behaves. First, we will review a three-step model for managing depression and then practice the model through roleplays and written exercises.

- Negative moods and depression are common among substance abusers during the recovery process. Often these moods are related to the actual depressant effects of drugs such as marijuana or alcohol or to the losses experienced in one's life (e.g., loss of friends or self-respect) as a result of substance use. Depression and negative moods often are ameliorated during treatment without any specific attention. However, some people continue to experience problems with depression even after they have been clean and sober for fairly long periods. In such cases, it may be necessary to focus directly on these negative moods and provide additional treatment.

- Depression is particularly problematic, because negative mood states, especially depression, often lead to relapse. Marijuana smoking does not help with depression and may even intensify it. Most people who use marijuana to help with depression are just as depressed when they come down as they were before they got high. They may even feel more depressed!

- Sometimes people feel helpless to change the way they feel. They say, "Everything is making me feel down! I can't change anything!" What they are really saying is that events in their lives are making or causing them to feel depressed—as in this model (draw the model on the board):

  Events → Feelings

- However, the model does not tell the whole story because events are not the only things that cause us to feel a certain way. How we think about events also influences how we feel—as in this more complete model (draw the model on the board):

  Events → Thoughts → Feelings

- It is helpful to remember that our thoughts can change the way we feel about an event because we often cannot control the event itself. But we *do* have control over how we *think* about an event. We can manage negative moods by changing the way we think and act. Many of the skills we have already learned for managing negative thoughts, solving problems, and increasing pleasant activities can also be used for dealing with depression and its symptoms.

Skill Guidelines (15 minutes)

Present the following talking points to participants.

- Here are three steps you can take to help yourself feel better when you are sad or depressed. We call them the **Three A's: (Become) Aware, Answer, and Act**. The first step is to become *aware* of thoughts that get you down. The second step is to *answer* these thoughts with new thoughts that are more positive and realistic. And the third step is to *act* on these new thoughts. It takes practice to use the Three A's, but once you get into the habit of using them, you can help yourself feel better.

- **Step #1: (Become) Aware.** The first step is to recognize when you are feeling depressed. Some signs that help tell you that you are depressed include the following (write list below on the board):

Signs of Depression:
- Inability to concentrate and problems with memory
- Difficulty getting things done or failing at school or work
- Inability to enjoy things that used to be fun
- Loss of confidence or difficulty making decisions
- Moodiness, crying, moping, talking about sadness, or thinking about suicide
- Low energy, feeling tired, or not having much energy
- Sleeping a lot or not being able to sleep
- Changes in weight: poor appetite or overeating.

These are easy to miss when you are actually feeling depressed, so it is important to become aware of them early on.

Feelings are not as easy to notice as you might think. Sometimes people are just too busy or too distracted to notice how they feel. Here are some good tips for helping you keep track of depressed feelings:

- **Pay attention to your mood changes.** When you start to feel sad, ashamed, bored, lonely, or rejected, tune in to what's going on and how you're feeling. Are you sleeping a lot, moping around, and eating differently from your normal pattern?

- **Own your feelings.** Take responsibility for your feelings. Use "I" statements such as "I feel," "I think," etc. If you are having trouble noticing your feelings, start talking about them. Tell people how you are really feeling at any given moment.

- **Check in with your body.** You can tell a lot about your feelings from your muscle tension, posture, facial expression, and how you walk and move.

- **Notice negative thoughts that you have when you are sad or depressed.** Negative thoughts can be a problem when they get to be automatic (i.e., like a habit) because much of the time they are just not true! For example, if a friend tells you that she does not want to go with you to the movies, a negative tape may start rolling in your head that says, "Nobody wants to go out with me." If that thought is allowed to keep repeating over and over, you might actually start believing it and start feeling alone and depressed—even though there are other friends who would go with you to the movies in a minute!

- **Step #2: Answer.** Once you start having negative thoughts, you can start answering them. First, you must separate what is really true from what a negative thought tells you is true. A good way to do this is to ask and answer some serious questions about yourself and your automatic thoughts.

  - **Ask, "What's the evidence?"** If you were a judge in a courtroom, would you be satisfied that there is enough evidence to prove that the negative thought is true? For example, your girlfriend did not call you tonight and now you have negative thoughts: "She is going to dump me!" The judge asks, "Is the fact that she didn't call enough evidence to prove that she is going to dump you?" (Well, not really. She might have been too busy. In fact, there could be many reasons why she didn't call.)

  - **Substitute a more realistic thought for the old one.** If the negative thought does not hold up in court, replace it with one that is more likely to be true, or wait until you can get

more evidence. For example, you might think, "Just because she did not call doesn't mean we're breaking up. I'll wait to see her in school tomorrow, and then I'll have a better idea of what's going on. In the meantime, I'm going to listen to some music and take my mind off this."

- **Step #3: Act.** Just answering your thoughts won't be enough to get over feeling depressed. Act on your new thought or belief. If you act differently, you can change old thinking habits and strengthen new ones. You have to do something to challenge your automatic thoughts. Here are some actions you can take to help overcome your depressed feelings.

  - **Make a short list of activities that make you feel good and another list of activities that make you feel bad.** Now make a plan for today that includes one or two extra feel-good activities and one or two fewer activities that make you feel bad.

  - **Use problem-solving strategies to take some action.** These can help you feel as if you are taking control of your life. Here are the steps:
    - ➤ Recognize that there is a problem.
    - ➤ Identify the problem.
    - ➤ Come up with solutions.
    - ➤ Make a decision.
    - ➤ Think about the result of your decision.

Activity Sheet (10 minutes)

This exercise was adapted from Auerbach (1997). Instruct participants to complete the *Activity Sheet for Thoughts*; this handout helps people become aware of negative thoughts. Ask group members to identify errors that characterize their thinking styles.

Group Exercise (15 minutes)

Have participants process the following scenario using the three A's—(become) aware, answer, act:

> You are grounded for the next 2 months because you came home high on marijuana one night and were caught by your parents. It is a long weekend, and no one is home, and you can't find anything to do. Your parents are not home and won't be back for a couple of hours. What are you thinking? How can you answer any thoughts you might have about wanting to get high? What can you do?

Real Life Practice Exercise (5 minutes)

Give group members the *Reminder Sheet for Depression Management, the Reminder Sheet for Thinking Errors*, and the *Real Life Practice Exercise for*

Managing Depression and Negative Thoughts handouts. Ask participants to review and complete these before the next session.

Session 11
Activity Sheet for Thoughts

(Adapted from Auerbach, 1997, pages 103 and 104)

The purpose of this worksheet is to give you practice in identifying automatic negative thoughts and then answering them. Below, write down one or two examples for each automatic negative thought that may cause problems for you. Then identify one or two answers that you can use to challenge your thoughts. A more complete list of these negative thoughts is on the *Reminder Sheet for Thinking Errors*.

1. BELIEVING IN PERFECTIONISM

Thinking that if you're not perfect, you're a loser

EXAMPLES:

_____

_____

ANSWERS:

_____

_____

2. CATASTROPHIZING or "AWFULIZING"

Taking something small that happened and exaggerating it

EXAMPLES:

_____

_____

ANSWERS:

_____

_____

3. OVERGENERALIZING

Thinking that if something happens once, it will happen every time

EXAMPLES:

_____

_____

ANSWERS:

_____

_____

4. EXPECTING THE WORST

Entering a new situation assuming that things won't work out

EXAMPLES:

_____

_____

(continued on next page)

ANSWERS:

_____

_____

5. PUTTING ONESELF DOWN

Thinking things that make you feel bad about yourself

EXAMPLES:

_____

_____

ANSWERS:

_____

_____

6. USING ALL-OR-NOTHING THINKING

Seeing things in black and white, with no in-between

EXAMPLES:

_____

_____

ANSWERS:

_____

_____

7. PERSONALIZING

Thinking all situations and events revolve around you or are about you

EXAMPLES:

_____

_____

ANSWERS:

_____

_____

8. MINDREADING

Assuming you know what other people are thinking

EXAMPLES:

_____

_____

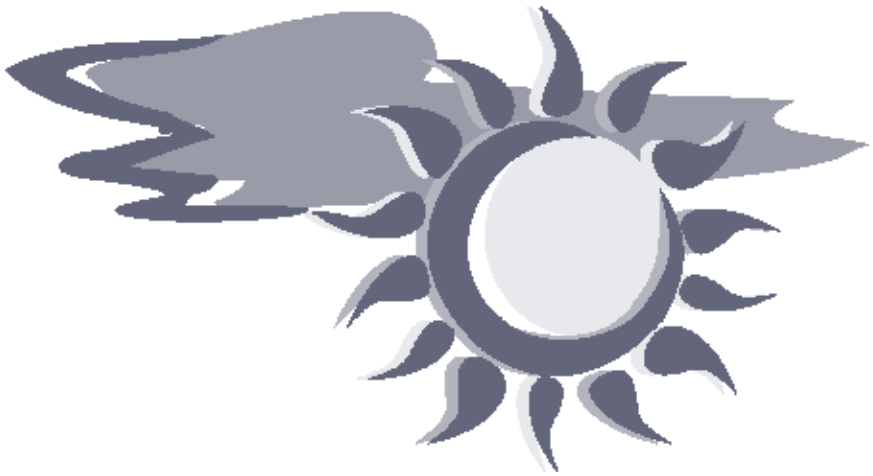
ANSWERS:

_____

_____

Session 11

Reminder Sheet for Depression Management



Use the Three A's to help overcome your depression.

Become AWARE of the symptoms of depression.

- Be aware of your moods and the situations that influence them.
- Be aware of your automatic negative thoughts.

ANSWER these thoughts.

- Ask questions and challenge the assumptions behind these thoughts.
- Replace the negative thoughts with positive ones.

ACT differently.

- Use your problem-solving skills to deal with issues that worry you.
- Increase your positive activities.
- Decrease your involvement in negative activities.
- Reward yourself for the positive steps you are making.

Session 11

Reminder Sheet for Thinking Errors

Is the way you're *seeing* it the way it really is?

(continued on next page)

Here's a list of how people *think* things are worse than they are. Are you doing any of these? What can you do differently?

Type of Error	Example
Personalizing: Thinking all situations and events are about you or revolve around you	"Everyone was looking at me and wondering why I was there. I know they must have been talking about me."
Magnifying: Blowing negative events out of proportion	"This is the worst thing that could happen to me."
Minimizing: Ignoring the positive factors of a situation or overlooking the negative factors of a situation	Ignoring the positive: "Acing that test was no big deal." Overlooking the negative: "Copping pot in a dangerous neighborhood is not a problem because nothing really bad happens."
Either/or thinking: Seeing things in black and white, with no in-between	"Either I'm a loser or I'm a winner; either I'm bad or I'm good."
Jumping to conclusions: Making a false connection between one set of circumstances and an outcome	"I blew the test; I'm never going to be able to get into college." "My heart is pounding. I must be having a heart attack."
Overgeneralizing: Thinking that if something happens once, it will happen every time	"I am never going to be able to quit smoking pot. I always screw up."
Self-blaming: Blaming yourself rather than identifying specific behaviors that you can change	"I'm no good."
Mindreading: Assuming you know what other people are thinking	"My mom is mad at me because she thinks I am getting high again."
Catastrophizing or "awfulizing": Taking something small that happened and exaggerating it	"Since I've already relapsed twice, I'll never be able to stay clean and sober."
Expecting the worst: Entering a new situation assuming that things won't work out, assuming you will fail before you even try to do something	"I'll never be able to pass this class. I may as well drop out."
Putting oneself down: Thinking things that make you feel bad about yourself	"I don't deserve things to get any better." "I am no good, just as my father [or mother] said."

Session 11

Real Life Practice Exercise for Managing Depression and Negative Thoughts

1. What are the ways I show my depression in moods, attitudes, and actions? What are the signs?

   _____
   _____
   _____
   _____

2. What are the negative thoughts that automatically go along with my depression? What do I think about my current situation, my world, and myself in general?

   _____
   _____
   _____
   _____

3. What questions can I ask myself to challenge these automatic negative thoughts?

   _____
   _____
   _____
   _____

4. What steps am I going to take to act differently? What problem-solving strategies have I come up with to deal with my problems? What pleasant activities might I increase? What unpleasant activities might I avoid or do less often?

   _____
   _____
   _____
   _____

Session 12: Managing Thoughts About Marijuana

Overview

Purpose: To help participants identify thoughts leading to marijuana use and manage those thoughts before relapse occurs

Total Time: 75 minutes

Breakdown:

- **Discussion of Urinalysis Results With Individual Group Members** (prior to group)
- **Review of Client Status** (10 minutes)
- **Review of Real Life Practice** (10 minutes)
- **Rationale for Coping Skill: Managing Thoughts About Marijuana** (10 minutes)
  - ➤ Thoughts about marijuana are normal.
  - ➤ It is important to be aware of these thoughts, so you don't act on them impulsively.
  - ➤ A risky state of mind can lead to 12 common excuses for relapse.
- **Skill Guidelines** (10 minutes)
  - ➤ Challenge thoughts about marijuana
  - ➤ List and recall benefits of not using
  - ➤ Recall unpleasant using experiences
  - ➤ Distract yourself with other thoughts
  - ➤ Reinforce your successes in coping with marijuana
  - ➤ Delay your decision to use
  - ➤ Leave or change the situation
  - ➤ Call someone
- **Group Exercise** (15 minutes)
- **Real Life Practice Exercise** (5 minutes)
- **Termination** (15 minutes)

Materials:

- A *Reminder Sheet for Managing Thoughts About Marijuana* handout for each group member
- A *Real Life Practice Exercise for Managing Thoughts About Marijuana* handout for each group member
- Writing materials for each group member
- A blackboard, "write and wipe" board, or large posterboard
- A session 12 *Managing Thoughts About Marijuana* poster (see appendix 1)

PROCEDURES: MANAGING THOUGHTS ABOUT MARIJUANA

Discussion of Urinalysis Results With Individual Group Members

Therapist Note: The results of the urinalysis specimens obtained in the last session should be discussed with participants before this group session. Guidelines for the presentation of urinalysis results can be found on page 24.

Review of Client Status (10 minutes)

Review with group members their efforts to achieve or maintain abstinence during the past week. Discuss participants' attempts to deal with current problems related to marijuana use. Reinforce any coping skills they have used successfully to avoid using marijuana.

Review of Real Life Practice (10 minutes)

Review the *Real Life Practice Exercise for Managing Depression and Negative Thoughts* handout assigned during session 11.

Rationale for Coping Skill: Managing Thoughts About Marijuana (10 minutes)

Present the following talking points to group participants. Adjust the presentation to the participants' ability to understand the concepts and terms being introduced.

- Thoughts about smoking marijuana are normal. Almost anyone who stops using alcohol and drugs occasionally thinks about getting high again. There is no problem with these thoughts, as long as you don't *act* on them. You may feel guilty about the thoughts (even though you have not acted on them), and you may even try to get them out of your mind. The purpose of this session is to identify those thoughts or feelings that can lead to relapse and learn new ways to catch yourself before you actually slip. Sometimes the thoughts are obvious, but sometimes they can creep up almost without being noticed.

- Recovering substance abusers need to be aware of the state of mind that can put them at risk for a relapse. A risky state of mind is one that tempts them to let down their guard. The negative thoughts of a risky state of mind can take the form of excuses. The 12 most common excuses for relapse (adapted from Kadden et al., 1992) are the following:

  1. **Happy memories of getting high.** Some people who are trying to stop using marijuana think about pot as they think about a long-lost friend. For example, "I remember the days when I'd take a few joints down to a party and get stoned"; "What's a weekend without pot and booze?"

  2. **Testing yourself.** Sometimes, after not smoking marijuana for a while, people get overconfident. For example, "I bet I can smoke with the guys tonight and still deal with school tomorrow morning." Sometimes, overconfidence is mixed with curiosity. For example, "I wonder what it would be like to have just one hit."

3. **Crisis.** During a crisis, a person may say, "I *need* a hit," or "I can handle this only with a joint."

4. **Feeling uncomfortable about life without marijuana.** Some people find that after they stop smoking pot, they are more aware of old or new problems in their lives. For example: "I'm very irritable around my friends. Maybe it's more important for me to be a nice person than it is for me to stop smoking right now," or "I'm no fun to be around when I'm not smoking pot."

5. **Self-doubts.** Some people doubt their ability to succeed at things. For example, "I just have no willpower," or "I tried to quit many times before and it never worked out; why should I expect this time to be any different?"

6. **Escape.** Most people want to avoid remembering unpleasant situations, problems, or past experiences. Failure, rejection, disappointment, embarrassment, or sadness tend to demand relief. People get tired of feeling hassled, lousy, and upset. They just want to get away from it all and away from themselves. They may not necessarily want to catch a buzz or get high, but they want instead to feel numb, calm, or at peace.

7. **Relaxation.** Thoughts of wanting to relax are perfectly normal, but the thoughts can be a problem if you expect to feel relaxed immediately without actually doing something relaxing. Rather than trying to do relaxing activities, the individual may choose the shortcut of using alcohol or drugs.

8. **Socialization.** Many people are shy or uncomfortable around new people or in social settings and may look to marijuana to feel more relaxed and confident.

9. **Improved self-image.** When people have low self-esteem or are unhappy with themselves, they often begin to think again about drugs as a way to feel more confident and to get immediate and temporary relief from feeling unhappy.

10. **Romance.** Most people enjoy daydreaming or having fantasies. When people are bored or unhappy with their lives, they want excitement, romance, and the feeling of being in love. Fantasizing, carried too far, can lead to using marijuana or alcohol to make fantasies seem real.

11. **To hell with it.** Some individuals seem to give up on setting any goals in their lives. They think that nothing really matters and that there is no reason to try. Why should they give a damn? Such an attitude leads these people to relax their guard and not to care whether they remain clean or not.

12. **No control.** This attitude is the opposite of the testing-yourself excuse. If people believe they can't control their cravings, they are setting themselves up for relapse. Those who feel they have no control may give up the fight before they have even tried to stop using drugs. This attitude differs from the to-hell-with-it attitude. In that situation, individuals do not necessarily feel powerless; they just do not want to make the effort to continue what they have been doing. No control implies just that—a feeling of being powerless over their cravings and the ability not to pick up drugs.

Skill Guidelines (10 minutes)

Explain that everyone who tries to stop smoking marijuana has thoughts about using it again at one time or another. Provide the following list of ways to manage these thoughts:

- **Challenge the thoughts.** For example: "Getting through high school is more important than getting high right now. I am going to get that diploma," "If my friends are real friends, they're going to respect that I want to do something else besides smoke pot," or "I can date without using and feel good about myself." An important aspect of challenging thoughts about substance abuse is not only to visualize what one is not going to do but to picture what one is going to do as an alternative to using.

- **List the benefits of not smoking pot.** The benefits might include increased self-esteem, greater self-control, staying out of legal trouble, and/or not disappointing friends and relatives. Paying more attention to the benefits (e.g., better health, improved memory, thinking more clearly) than to the losses (e.g., not getting high) will strengthen your decision not to use. You might also carry a small index card in your wallet or pack to remind you of the benefits of staying clean whenever you catch yourself being tempted to use.

- **List unpleasant marijuana experiences.** Try to remember the bad feelings you have had as a result of marijuana use. Make a list of unpleasant experiences such as arrests, family problems, poor grades, or paranoia. Try to picture a negative experience you have had with marijuana. Add these bad feelings and unpleasant experiences to your index card.

- **Distract yourself with other thoughts.** Think about something besides marijuana. For example, think about holiday plans, people you love, or hobbies. Focus on something else you want to get done.

- **Reinforce your successes in coping with marijuana.** Remind yourself of the success you have had so far. For example: 12 weeks of abstinence, getting involved in treatment, or staying in treatment.

- **Delay your decision to use.** Put off the decision to use drugs for 30 minutes. Most urges to use are like waves: they build up, peak, and then fade away. If you wait, the wave will pass.

- **Leave or change the situation.** If a place or activity makes you think about using marijuana, go somewhere else or try a different activity.

- **Call someone who is good at helping you talk through a problem.** That person may be able to help you clarify your thoughts or distract you.

Group Exercise (15 minutes)

Have participants think of their own excuses for using marijuana and select ways of coping with these excuses from the list above. For example:

- **Excuse:** "Quitting pot has really been easier than I thought. I must not have been all that addicted to it in the first place."

- **Coping strategy:** Challenge the thoughts. "I must be crazy. What am I saying? Quitting hasn't been easy. I was having the urge to smoke all the time until the last few days. If I didn't depend on it, I could have quit on my own a long time ago. I'm just missing the feeling of being high and starting to talk myself out of quitting. I think I'll do something else."

Real Life Practice Exercise (5 minutes)

Ask participants to write lists of items under the following three categories. Each list should consist of at least 5 to 10 items.

- Positive consequences you expect by not using drugs
- Negative consequences of using drugs
- The most high-risk situations you might run into that will make quitting or staying clean difficult.

Ask participants to use this information to rate how committed they are to stopping their marijuana use and to quitting. Ratings range from 1 (no commitment) to 10 (extremely high level of commitment).

Termination (15 minutes)

> **Therapist Note:** It is important to address termination before the final session. Beginning in session 9, therapists should broach the topic of termination. The first mention of termination may be brief. However, therapists should note that a limited number of sessions remain, review how these sessions will be spent, and probe for any questions or reactions from participants.

Termination can be problematic for many participants and can lead to clinical deterioration or acting out prior to the end of treatment. Several weeks before the end of treatment, therapists should review the treatment timetable to sensitize themselves and participants to the issues involved.

During the final session, devote an adequate amount of time to termination issues. At a minimum, termination should include reviewing and summarizing the course of treatment, eliciting the participant's reactions and feelings about treatment, inquiring about the pros and cons of the treatment for the participant, and discussing the participant's future plans. Fifteen to twenty minutes, in most cases, should be adequate for processing termination.

Therapist's Feedback to the Group Members

During termination, the therapist should model how to give positive feedback and how to provide suggestions for continued change. The therapist's feedback to the group members should be brief and nonjudgmental and should project a positive view of the future. It may include references to participants' progress toward stated goals, as well as any contributions group members may have made to the success of a peer or the group as a whole. The therapist may use this as an opportunity to suggest future changes and identify areas needing further development. Group members should be urged to build on their accomplishments during group and to continue making positive changes in their lives.

Feedback Among Group Members

Group members have shared many experiences and discussed intimate aspects of one another's lives. They are able to provide valuable feedback on one another's progress and areas needing additional attention. This structured activity for providing feedback is the final opportunity to interact with one another and is an appropriate conclusion to the group's work together. Participants should be encouraged to be supportive and focus on positive achievements.

Group Feedback to the Therapist

Group members should also be encouraged to provide positive and negative comments regarding their group experience to the therapist. This feedback should include recommendations for improving groups, as well as comments on the therapist's style. Because participants are less accustomed to this role, they may need prompting and reminding about using the coping skills learned in the group (e.g., being assertive rather than aggressive or passive; giving constructive rather than destructive criticism). The therapist can ask group members about experiences that were especially helpful or meaningful and can get their reactions to the assigned *Real Life Practice Exercises*. The therapist can elicit comments about his or her performance as a group leader (e.g., the degree to which he or she was helpful, his or her openness to suggestions). Most participants will use this opportunity to

provide appropriate and useful information. In rare instances, a client will abuse this opportunity. However, prompt, assertive intervention can turn destructive criticism into an opportunity to model important skills to the group.

Goodbyes

Allow plenty of time for group members to say goodbye. This process will undoubtedly have already begun during the feedback phase of this session.

Session 12

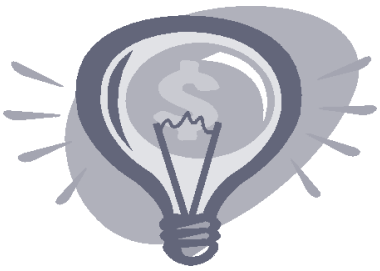
Reminder Sheet for Managing Thoughts About Marijuana

Here are some ways to manage thoughts about marijuana use:

- **Challenge your thought.** Do you really need to get high? Can you have fun without smoking a joint?
- **Think of the benefits of not using drugs.** This might include increased self- esteem, greater self-control, better health, improved memory, thinking more clearly, staying out of legal trouble, and/or not disappointing friends and relatives.
- **Remember negative drug experiences or problems you have had as a result of getting high.** These might include arrests, family problems, poor grades, or paranoia.
- **Distract yourself with other thoughts.** Think of something besides marijuana.
- **Reinforce your successes.** Think about how long ago you quit, how you got involved in treatment, and why you have stayed in treatment
- **Focus on the positive.** Think of the benefits you gain from not using.
- **Use photographs of people who will be disappointed if you relapse.**
- **Delay your decision to use.** If nothing else is working, then look at your watch and put off the decision to use for 30 minutes or more.
- **Leave or change the situation.** If a place or activity makes you think about using marijuana, go somewhere else or try a different activity.
- **Call someone, and try to talk it out.** This person may be able to help you clarify your thoughts or distract you.

Session 12

Real Life Practice Exercise for Managing Thoughts About Marijuana



One way to cope with thoughts about marijuana is to remind yourself of the benefits of not using and of the negative effects that marijuana has had on your life. Make a list of these reminders on this sheet. Then copy this list onto a pocket-sized index card. Read the card whenever you have a craving to smoke marijuana.

Benefits of not using marijuana:

_____
_____
_____
_____
_____

Negative effects of using marijuana:

_____
_____
_____
_____
_____

High-risk situations that will tempt me to get high:

_____
_____
_____
_____
_____

Sources for Sessions 6–12

Session 6, Problem Solving: Material was adapted from the following sources:

Problem-Solving Approach

- Dennis, M. L., Fairbank, J. A., Bonito, A. J., Rourke, K. M., Karuntzos, G. T., Roland, E. J., Caddell, J. M., Woods, M. G., Rachal, J. V., Bossert, K. E., & Burks, M. E. (1995). *Individual substance abuse counseling (ISAC) manual*. Bloomington, IL: Chestnut Health Systems, Lighthouse Institute Publications.

- D'Zurilla, T., & Goldfried, M. (1971). Problem-solving and behavioral modification. *Journal of Abnormal Psychology, 78*, 107–126. Copyright © 1971 by the American Psychological Association. Adapted with permission.

Reminder Sheet for Problem Solving and *Real Life Practice Exercise for Problem Solving* handouts

- Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: The Guilford Press. Copyright © 1989 by The Guilford Press.

Session 7, Anger Awareness: Material was adapted from the following sources:

Cognitive-Behavioral Model of Anger

- Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: The Guilford Press. Copyright © 1989 by The Guilford Press.

Relaxation Training

- Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: The Guilford Press. Copyright © 1989 by The Guilford Press.

- Steinberg, K., Carroll, K., Roffman, R., & Kadden, R. (1997). *Marijuana treatment project: Clinical manual* (unpublished).

Anger Triggers Activity Sheets

- Auerbach, S. (1997). *Clean and coping manual* (unpublished).

- Clarke, G., Lewinsohn, P., & Hops, H. (1990). *Leader's manual for adolescent groups: Adolescent coping with depression course*. Eugene, OR: Castaglia Publishing Company.

Session 8, Anger Management: Material was adapted from the following source:

Rationale, Reminder Sheet, and Real Life Practice Exercise

- Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: The Guilford Press. Copyright © 1989 by The Guilford Press.

Session 9, Effective Communication: Material was adapted from the following sources:

Active Listening

- Clarke, G., Lewinsohn, P., & Hops, H. (1990). *Leader's manual for adolescent groups: Adolescent coping with depression course.* Eugene, OR: Castaglia Publishing Company.

- Auerbach, S. (1997). *Clean and coping manual* (unpublished).

Skill Guidelines, Receiving Criticism Rationale, Types of Criticism, and Real Life Practice Exercise

- Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: Guilford Press. Copyright © 1989 by The Guilford Press.

Session 10, Coping With Cravings and Urges To Use Marijuana: Material was adapted from the following sources:

Rationale, Reminder Sheet, Coping With Cravings Activity Sheet, and Real Life Practice Exercise

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

Learning New Coping Strategies

- Steinberg, K., Carrol, K., Roffman, R., & Kadden, R. (1997). *Marijuana treatment project: Clinical manual* (unpublished).

Session 11, Depression Management: Material was adapted from the following sources:

Rationale, Cognitive Thinking Errors, Reminder Sheet, and Real Life Practice Exercises

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

Session Activity Sheet and Session Activity

- Auerbach, S. (1997). *Clean and coping manual* (unpublished).

Session 12, Managing Thoughts About Marijuana: Material was adapted from the following sources:

Rationale, Skill Guidelines, Reminder Sheet, Real Life Practice, and Termination

- Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: The Guilford Press. Copyright © 1989 by The Guilford Press.

Rationale

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

V. Glossary of Terms

Adolescent community reinforcement approach: A treatment approach that includes individual sessions with the adolescent or his or her concerned others or both. Clients learn alternative skills to cope with problems and meet needs; the adolescent's environment is emphasized.

Affective management: The ability to modulate intense emotions by attending to the thoughts and circumstances that maintain them.

Aggressive: A state or an attitude characterized by aggression or aggressiveness; a tendency to press one's own interests or ideas despite opposition.

Amotivational syndrome: A condition characterized by apathy, decreased attention span, poor judgment, diminished capacity to carry out long-term plans, social withdrawal, and a preoccupation with acquiring marijuana. The condition is often attributed to heavy cannabis use and has been observed in adolescents.

Assertive: A state or an attitude characterized by boldness or confidence.

Attention deficit/hyperactivity disorder: A neurologically based disorder that occurs in both adults and children who have significant problems with inattention, impulsivity, hyperactivity, and boredom.

Automatic negative thoughts: Ideas or thoughts that are not conducive to positive change; a symptom of depression.

Awfulizing: Taking something small and exaggerating it.

Catastrophizing: Exaggerating a small event ("Since I've already relapsed twice, I'll never be able to stay clean or sober.").

Cognitive behavioral therapy: An approach to treatment that focuses on the client's thoughts, feelings, and behaviors associated with substance use.

Counterattack: A challenge to a statement or idea.

Direct triggers: A direct verbal or nonverbal attack (e.g., physical attack, obscene gesture, unfair treatment) or frustration resulting from being unable to get something.

Disclosure: Shared information.

Dissonance conflict: The discomfort experienced by an individual when confronted with his or her professed desire to abstain from continued substance use.

Either/or thinking: Seeing things in black and white, with no in-between ("I'm either a loser or a winner; I'm either bad or good.").

Emotional identification: A subcomponent of affective management; the act of detecting, interpreting, and feeling cues accurately.

Emotional management: A subcomponent of affective management; the process of checking escalating anger or depression so that the individual can focus energy on solving problems.

Family support network: A family-focused treatment approach designed to improve parenting skills and increase family cohesion, closeness, and parental support.

Gateway phenomenon: A developmental perspective on substance abuse that assumes that the use of less harmful substances (e.g., alcohol, marijuana, tobacco) raises the risk for subsequent use of more harmful substances (e.g., cocaine, heroin).

Indirect triggers: Seeing an attack on someone else or being aware of one's thoughts and feelings about a situation (e.g., feeling that one is being blamed, thinking that someone is disappointed in you, feeling that people expect too much from you).

Magnifying: Blowing negative events out of proportion ("This is the worst thing that could happen to me.").

Mindreading: Assuming what other people are thinking ("My mom is mad at me because she thinks I'm getting high again.").

Minimizing: Ignoring the positive factors ("Acing that test was no big deal.") or overlooking the negative factors of a situation ("Copping pot in a dangerous neighborhood is not a problem because nothing really bad happened.").

Motivational enhancement therapy: An approach to treatment that focuses and builds a client's intrinsic motivation to abstain from or reduce unwanted behavior.

Motivational interviewing: An interview technique in which the therapist reinforces indications of motivation to change and explores ambivalence that may pose a significant barrier to abstinence. Reinforcement is accomplished by exploring a participant's reasons for seeking treatment, prior treatment episodes, previous attempts to quit, treatment goals, and perceptions of self-efficacy.

Multidimensional family therapy: A family-focused treatment that requires therapists to work individually with adolescents and their families in 12 weekly sessions.

Overgeneralizing: Thinking that if something happens once, it will happen every time ("I'm never going to be able to quit smoking pot. I always screw up.").

Passive: A state or an attitude characterized by rest or inactivity. A person with this attitude makes no effort to control the course of events.

Passive-aggressive: A state or an attitude characterized by a lack of genuine independence. A person with this attitude reacts to difficulties either by indecisiveness and clinging to others for help or by irritability, temper tantrums, and destructiveness or obstructionism.

Personalized feedback report (PFR): A form that presents questions to gather client information for intake assessment instruments. A completed PFR highlights the adolescent's problems and concerns related to marijuana use and can be used to compare his or her marijuana use with national adolescent norms.

Personalizing: A thinking error characteristic of depressed thoughts, such as thinking all situations and events revolve around oneself ("Everyone was looking at me and wondering why I was there. I know they must have been talking about me.").

Positive outcome expectancy: A heightened belief in the benefit of using drugs.

Rephrase: To reword.

Self-attribution: Ascribing an outcome to oneself as opposed to environmental circumstances.

Self-blaming: Blaming oneself rather than identifying specific behaviors that can be changed.

Self-efficacy: An individual's confidence in his or her ability to abstain from unwanted behaviors.

Self-talk: A coping response to temporarily distract oneself and check one's reactive emotions.

Skill guidelines: Techniques for participants to follow when they need a coping response to reduce the likelihood of future marijuana use. The key to engaging adolescents is to make the guidelines "come alive" through examples and clearly explain their relevance in participants' lives. The posters in appendix 1 highlight the skill guidelines taught in each group session.

Tension relaxation exercise/progressive relaxation/deep muscle relaxation: Procedures that involve tensing and relaxing different muscle groups to identify feelings of tension and replace them with feelings of relaxation.

Thought changing: A relapse prevention technique whereby a participant can act to resist addictive behavior.

Triggers: Thoughts, feelings, or events that cause an urge or craving to use marijuana.

VI. References

Abikoff, H., & Gittleman, R. (1985). Hyperactive children treated with stimulants: Is cognitive training a useful adjunct? *Archives of General Psychiatry, 42*, 953–965.

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

Auerbach, S. (1997) *Clean and coping manual.* Unpublished.

Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: A review. *Addictions, 88*, 315–336.

Brown, R. T., Wynne, K. A., & Medemis, R. (1985). Methylphenidate and cognitive therapy: A comparison of treatment approaches with hyperactive boys. *Journal of Abnormal Psychology, 13*, 69–88.

Bunch, L., Hamilton, N., Tims, F., Angelovich, N., & McDougal, B. (1998). *Family support network (FSN, version 1.0)*. Unpublished.

Camp, B. W. (1977). Verbal mediation in young aggressive boys. *Journal of Abnormal Psychology*, *86*, 145–153.

Clarke, G., Lewinsohn, P., & Hops, H. (1990). *Leader's manual for adolescent groups: Adolescent coping with depression course*. Eugene, OR: Castaglia Publishing Company.

Cohen, S. (1979). A new ball game. *Drug Abuse and Alcoholism Newsletter, 8*(4).

Cohen, S. (1980). Cannabis: Impact on motivation, Part I. *Drug Abuse and Alcoholism Newsletter, 9*(10).

Cohen, S. (1981). Cannabis: Impact on motivation, Part I. *Drug Abuse and Alcoholism Newsletter, 10.*

Dennis, M. L., Babor, T., Diamond, G. C., Donaldson, J., Godley, S., Tims, F., Chirkos, T., Fraser, J., French, M. T., Glover, F., Godley, M., Hamilton, N., Herrell, J., Kadden, R., Kaminer, Y., Lennox, R., Liddle, H., McGeary, K. A., Sampl, S., Scott, C., Titus, J., Unsicker, J., Webb, C., & White, W. L. (1998). *Treatment for cannabis use disorders general research design and protocol for the Cannabis Youth Treatment (CYT) Cooperative Agreement*. Bloomington, IL: Chestnut Health Systems.

Dennis, M. L., Fairbank, J. A., Bonito, A. J., Rourke, K. M., Karuntzos, G. T., Roland, E. J., Caddell, J. M., Woods, M. G., Rachal, J. V., Bossert, K. E., & Burks, M. E. (1995). *Individual substance abuse counseling (ISAC) manual*. Bloomington, IL: Chestnut Health Systems, Lighthouse Institute Publications.

Donovan, J. E., & Jessor, R. (1985). Structure of problem behavior in adolescence and young adulthood. *Journal of Consulting and Clinical Psychology, 53*, 890–904.

Douglas, V. I., Parry, P., Marton, P., & Garrison, C. (1976). Assessment of a cognitive training program for hyperactive children. *Journal of Abnormal Child Psychology, 4*, 389–410.

Dryfoos, J. G. (1990). *Adolescents at risk: Prevalence and prevention.* New York: Oxford University Press.

D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78,* 107–126.

Farrell, M., Danish, S. J., & Howard, C. W. (1992). Relationship between drug use and other problem behaviors in urban adolescents. *Journal of Consulting and Clinical Psychology, 60,* 605–712.

Godley, S. H., Adams, L., Dennis, M. L., Godley, M. D., & White, W. L. (May 1996*a*). Case management for adolescent substance abusers: The need, critical issues, and recommendations for further study. In H. A. Seigal & R. C. Rapp (Eds.). *Case management and substance abuse treatment: Perspectives, methods and experience*. Symposium conducted at Wright State University School of Medicine, Dayton, Ohio.

Godley, M. D., Markwood, A., Lesch, W., Grimm, J. L., Blue, R., & Robinson, D. (1996*b*). Youth study on substance use: Comparing the 1990, 1993, and 1995 results. Bloomington, IL: Illinois Department of Alcoholism and Substance Abuse and Lighthouse Institute Publications.

Hall, W. (1995). The health risks of cannabis. *Australian Family Physician, 24,* 1237–1240.

Hamilton, N. L., Brantley, L. B., Tims, F. M., Angelovich, N., & McDougall, B. (2001). *Family support network for cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 3.* DHHS Pub. No. (SMA) 01–3488. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Hartwell, S., Ungemack, J., Babor, T. F., Stevens, M., & Del Boca, F. (1996). *State of Connecticut: Adolescent substance abuse treatment needs assessment: The 1995 adolescent alcohol and drug use school survey.* Farmington, CT: University of Connecticut Health Center.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64–105.

Hinshaw, S. P., Henker, B., & Whalen, C. K. (1984). Cognitive-behavioral and pharmacologic interventions for hyperactive boys: Comparative and combined effects. *Journal of Consulting and Clinical Psychology, 52*(5), 739–749.

Hops, H., & Lewinsohn, P. (1995). A course for the treatment of depression among adolescents. In D. Craig & K. Dobson (Eds.), *Anxiety and depression in adults and children* (pp. 230–245). Thousand Oaks, CA: Sage Publications, Inc.

Institute for Social Research. (1997). *Monitoring the Future Study, 1997.* Ann Arbor, MI: University of Michigan. www.monitoringthefuture.org [accessed March 2001].

Jessor, R., & Jessor, S. L. (1977). The social-psychological framework. In R. Jessor & S. L. Jessor (Eds.), *Problem behavior and psychosocial development: A longitudinal study of youth* (pp. 17–42). New York: Academic Press.

Johnson, R. A., Hoffman, J. P., & Gerstein, D. R. (1996). *The relationship between family structure and adolescent substance use.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

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

Kaminer, Y., & Blitz, K. (1995). *Cognitive behavioral therapy for adolescent substance abusers.* Unpublished.

Kandel, D. B. (1982). Epidemiological and psychosocial perspectives and adolescent drug use. *Journal of the American Academy of Child and Adolescent Psychiatry, 21,* 328–347.

Kandel, D. B., & Davies, M. (1996). High school students who use crack and other drugs. *Archives of General Psychiatry, 53,* 71–80.

Kandel, D. B., & Faust, R. (1975). Sequences and stages in patterns of adolescent drug use. *Archives of General Psychiatry, 32,* 923–932.

Kandel, D. B., & Yamaguchi, K. (1993). From beer to crack: Developmental patterns of involvement in drugs. *American Journal of Public Health, 83,* 851–855.

Kazdin, A. E., Bass, D., Siegal, T., & Thomas, C. (1989). Cognitive-behavioral therapy and relationship therapy in the treatment of children referred for antisocial behavior. *Journal of Consulting and Clinical Psychology, 57,* 522–535.

Kendall, P. C., Reber, M., McCleer, S., Epps, J., & Roman, K. R. (1990). Cognitive-behavioral treatment of conduct-disordered children. *Cognitive Therapy and Research, 14,* 279–297.

Kendall, P. C., & Wilcox, L. E. (1980). A cognitive-behavioral treatment for impulsivity: Concrete vs. conceptual training in non-self-controlled problem children. *Journal of Consulting and Clinical Psychology, 47,* 1020–1029.

Kleinman, P., Wish, E., Deren, S., Rainone, G., & Morehouse, E. (1988). Daily marijuana use and problem behaviors among adolescents. *International Journal of the Addictions, 23,* 87–107.

Lundqvist, T. (1995). Specific thought patterns in chronic cannabis smokers observed during treatment. *Life Sciences, 56*(23/24), 2141–2144.

Marlatt, G. A., & Gordon, J. R. (Eds.) (1985). *Relapse prevention.* New York: Guilford Press.

Meichenbaum, D. H., & Goodman, J. (1971). Training impulsive children to talk to themselves: A means of developing self-control. *Journal of Abnormal Psychology, 77*(2), 115–126.

Millsaps, C. L., Azrin, R. L., & Mittenberg, W. (1994). Neuropsychological effects of chronic cannabis use on memory and intelligence of adolescents. *Journal of Child and Adolescent Substance Abuse, 3,* 47–55.

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

Musty, R. E., & Kaback, L. (1995). Relationships between motivation and depression in chronic marijuana users. *Life Sciences, 56*(23/24), 2151–2158.

National Institute on Drug Abuse. (1986). Marijuana. *NIDA Capsules*, Washington, DC: Government Printing Office.

Nowinski, J. (1990). *Substance abuse in adolescents and young adults: A guide to treatment.* New York: W. W. Norton and Company.

Rob, M., Reynolds, I., & Finlayson, P. F. (1990). Adolescent marijuana use: Risk factors and implications. *Australian and New Zealand Journal of Psychiatry, 24,* 47–56.

Sampl, S., & Kadden, R. (2001). *Motivational enhancement therapy and cognitive behavioral therapy for adolescent cannabis users: 5 sessions, Cannabis Youth Treatment (CYT) Series, Volume 1.* DHHS Pub. No. (SMA) 01–3486. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Sarason, I. G., & Ganzer, B. R. (1973). Modeling and group discussion in the rehabilitation of juvenile delinquents. *Journal of Counseling Psychology, 20,* 442–449.

Sarason, I. G., & Sarason, B. R. (1981). Teaching cognitive and social skills to high school students. *Journal of Consulting and Clinical Psychology, 49,* 908–918.

Schwartz, R. H. (1987). Marijuana: An overview. *Pediatric Clinics of North America, 34,* 305–317.

Solowij, N. (1995). Do cognitive impairments recover following the cessation of cannabis use? *Life Sciences, 56*(23/24), 2119–2126.

Solowij, N., Grenyer, B., Chesher, G., & Lewis, J. (1995). Biopsychosocial changes associated with cessation of cannabis use: A single case study of acute and chronic cognitive effects, withdrawal and treatment. *Life Sciences, 56*(23/24), 2127–2134.

Steinberg, K., Carroll, K., Roffman, R., & Kadden, R. (1997). *Marijuana treatment project: Clinical manual*. Unpublished.

Stephens, R. S., Roffman, R. A., & Simpson, E. E. (1994). Treating adult marijuana dependence: A test of the relapse prevention model. *Journal of Consulting and Clinical Psychology, 62,* 92–99.

Substance Abuse and Mental Health Services Administration (2001*a*). *Summary of findings from the 2000 National Household Survey on Drug Abuse.* Rockville, MD: Office of Applied Studies. www.samhsa.gov/oas/NHSDA/2KNSDA/appendixf1.htm [accessed March 6, 2002].

Substance Abuse and Mental Health Services Administration (2001*b*). *Year-end 2000 emergency department data from the Drug Abuse Warning Network*. Rockville, MD: Office of Applied Studies.

Zweben, A., Barrett, D., Carty, K., McRee, B., Morse, P., & Rice, C. (Eds.) (1998). *Strategies for facilitating compliance in alcoholism treatment research.* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Appendix 1.

Miniatures of 11- by 17-inch Posters for CBT7 Sessions 6–12

Cognitive Behavioral Therapy

Group Mission: To learn and practice coping skills that will help you identify triggers and beliefs, manage moods and emotions, strengthen self-esteem, improve relationships, and maintain abstinence from substance abuse and other high-risk behaviors.

Assumption #1: We all have problems getting along with other people and handling our moods and feelings.

Assumption #2: Problems in getting along with other people and trouble managing feelings often set the stage for drug use. Marijuana use often occurs in high-risk situations such as feeling frustrated with someone, being offered a joint at a party, or feeling depressed, angry, sad, or lonely.

Therefore: The goal of this group is to teach skills that you can use to cope with your own high-risk situations. We will focus on ways to handle difficult situations with other people more effectively and teach ways to handle feelings and moods that may be difficult for you.

Group Therapy Ground Rules

1. Do not come to a session if you are high or drunk.
2. Maintain confidentiality—in other words, "What's said here, stays here."
3. Work on maintaining abstinence.
4. Attend every session or cancel in advance.
5. Show up on time.
6. Do not leave the group without permission.
7. Complete all *Real Life Practice Exercises*.
8. Do not wear clothing that has symbols of gangs or drugs or revealing clothing. Do not bring electronic equipment or other distractions.
9. Listen to one another; one person speaks at a time without being interrupted.
10. Take responsibility for yourself. Own your behavior. Use "I" statements.
11. Do not tell war stories about drug use or gang involvement.
12. Do not use verbal abuse, threatening words, or threatening behavior.
13. Verbalize your commitment to abstinence and sobriety.

Session 6
Problem Solving

Rationale

- Problems are a part of everyday life. A situation becomes a problem if there is no immediate effective way for a person to handle it.

- Coming up with an effective solution requires that you slow down and check out the situation so you can decide what will work best for you. You have to **Stop and Think!**

Skill Guidelines

1. **Recognize that a problem exists.** Is there a problem?

2. **Identify the problem.** Stop and think. What is the problem?

3. **Come up with solutions.** What can I do? Think ahead. What are the consequences of each solution?

4. **Make a decision.** Do it.

5. **Evaluate the outcome.** Did this work for me?

Session 7
Anger Awareness

Rationale

Anger is a normal human emotion. However, there is a difference between anger as a <u>feeling</u> and the negative <u>consequences</u> of anger, such as aggression, impulsivity, and passivity.

TRIGGER → ANGRY THOUGHTS → BEHAVIOR

Everyone has different ways of communicating his or her anger toward other people. The way you handle anger can have either constructive or destructive effects.

<u>Destructive:</u> Aggressive, passive, passive-aggressive

<u>Constructive:</u> Assertive

Skill Guidelines

Become more aware of situations that trigger anger:

- Direct
- Indirect

Become more aware of internal reactions to anger:

- Feelings
- Physical reactions
- Mix of physical reactions and feelings
- Sleep problems
- Fatigue or depression

Session 8
Anger Management

Rationale

Anger is caused by thoughts and beliefs about a particular situation.

Most people think that: *Events* (A) → *Anger* (C)

When really it is: *Events* (A) → *Thoughts* (B) → *Anger* (C)

Skill Guidelines

1. Calm down.
   Chill out.

2. THINK about the situation.
   Collect your thoughts.

3. THINK through your options.
   Choose the best action.

4. Let it go (if anger is unresolved).
   Change the way you think.

CONGRATULATE YOURSELF!

SESSION 9
EFFECTIVE COMMUNICATION AND RECEIVING CRITICISM

RATIONALE

- CRITICAL STATEMENTS ARE ENCOUNTERED IN EVERYDAY LIFE.
- CRITICISM APPROPRIATELY PROVIDES US WITH A CHANCE TO LEARN THINGS ABOUT OURSELVES AND ABOUT HOW OUR BEHAVIOR AFFECTS OTHER PEOPLE.

TWO TYPES OF CRITICISM:

1. CONSTRUCTIVE: DIRECTED AT THE BEHAVIOR, NOT AT THE PERSON
   PEOPLE CAN CHANGE THEIR BEHAVIOR

2. DESTRUCTIVE: FOCUSES ON THE PERSON RATHER THAN THE BEHAVIOR

SKILL GUIDELINES

- DON'T GET DEFENSIVE, DON'T ARGUE, DON'T TRY TO GET BACK AT THE OTHER PERSON.
- ASK QUESTIONS IF YOU DON'T UNDERSTAND THE CRITICISM.
- FIND SOMETHING TO AGREE WITH ABOUT THE CRITICISM.
- PROPOSE A COMPROMISE.
- REJECT UNFAIR CRITICISM.

CRITICISM RELATED TO SUBSTANCE ABUSE:

- ACCUSATIONS OR INQUIRIES ABOUT DRUG USE
- A FOCUS ON PAST EVENTS OR PAST NEGATIVE CONSEQUENCES
- AN ISSUE MADE OF OTHER BEHAVIORS RELATED TO PAST MARIJUANA USE

Session 10
Coping With Urges and Cravings To Use Marijuana

Rationale

- A craving may be an uncomfortable experience, but it is common and does not mean something is wrong.
- Urges and cravings can be triggered by things you see in the environment or by situations that remind you of using marijuana.
- Urges and cravings usually last only a few minutes or at most a few hours; they usually peak and then die down, like a *wave*. Learning coping skills helps reduce how often and how intensely you experience an urge.

Skill Guidelines

- *Recognize triggers* (seeing someone getting high, drinking, or using other drugs; being around friends or family who drink or use drugs; and experiencing negative feelings).
- *Avoid/decrease exposure*. Limit how often you will have to be in these high-risk situations.
- *Distract yourself*. Entertain yourself with another activity.
- *Talk it through* with a family member or friend when you want to get high or drunk.

Session 11
Depression Management

Rationale

- Negative moods and depression are common during recovery. They may be due to the lingering effects of drugs in your body or because of problems caused by your drug or alcohol use. Although depression usually gets better with abstinence, some people still feel depressed for a while.

- Depression can lead to relapse if you do not learn to manage negative feelings in a more productive way.

Skill Guidelines

Change How You Think! The Three A's

- ***(Become) AWARE** of negative thinking.*
- ***ANSWER** negative thoughts.*
- ***ACT** on new thoughts.*

Session 12
Managing Thoughts About Marijuana

Rationale

- Learn to identify thoughts and feelings that lead to marijuana use.
- Learn how to catch yourself before you slip.

Skill Guidelines

Here are some ways to manage your thoughts:

1. Challenge them.
2. List benefits of NOT using.
3. List negative experiences with using.
4. Distract yourself.
5. Reward yourself.
6. Delay your decision to get high.
7. Leave or change the situation.
8. Call someone.

Appendix 2. Therapist Forms

MET/CBT5 + CBT7 Treatment Plan

Therapist Self-Rating Form
MET/CBT5 + CBT7 Therapist Group Session Report

MET/CBT5 + CBT7 Treatment Plan

Participant_____ Therapist_____

Date	Session Delivered	Clinical Note
	Session 1: Motivation Building	
	Session 2: Goal Setting	
	Session 3: Marijuana Refusal Skills	
	Session 4: Enhancing the Social Support Network and Increasing Pleasant Activities	
	Session 5: Planning for Emergencies and Coping With Relapse	
	Session 6: Problem Solving	
	Session 7: Anger Awareness	
	Session 8: Anger Management	
	Session 9: Effective Communication	
	Session 10: Coping With Cravings and Urges To Use Marijuana	
	Session 11: Depression Management	
	Session 12: Managing Thoughts About Marijuana	

Therapist Self-Rating Form
MET/CBT5 + CBT7 Therapist Group Session Report

Instructions

- Provide identifying information at the beginning of the form.
- For each question, circle the number of the appropriate response and, when asked, write in a response on the lines provided.
- When responding to specific items, refer to the following response set:
  1. not at all: The intervention was not delivered in that session.
  2. a little: The intervention was presented but only briefly mentioned and not covered in depth or with great frequency.
  3. somewhat: The intervention was presented with some frequency but not covered in depth.
  4. considerably: The intervention was presented frequently and in depth and was covered in great detail.
  5. extensively: The intervention clearly dominated the session.

In general, most interventions should be rated 2 or 3; ratings of 4 or 5 should be comparatively rare and used only when a particular intervention truly characterized the bulk of a session. Any significant clinical information relevant to the session should be documented in the additional notes section.

Intervention used (circle)

1 = MET/CBT5
2 = MET/CBT5 + CBT7
3 = MET/CBT5 + CBT7 + FSN

____ Makeup Session

____ Number of Participants

Participants_____
_____
Therapist_____
Date _____
Session #_____

Date and time of next scheduled session: _____

1) What **topic** was covered in this session?
   6 = CBT6, Problem Solving
   7 = CBT7, Anger Awareness
   8 = CBT8, Anger Management
   9 = CBT9, Effective Communication
  10 = CBT10, Coping With Cravings and Urges To Use Marijuana
  11 = CBT11, Depression Management
  12 = CBT12, Managing Thoughts About Marijuana

   A) If this was session 6 (CBT6), did you also cover the topic of **problem recognition**?
      1 = Yes
      2 = No

   B) If this was session 7 (CBT7), did you also cover the topic of **relaxation training**?
      1 = Yes
      2 = No

C) If this was session 9 (CBT9), did you **roleplay** both appropriate and inappropriate responses to receiving criticism?
1 = Yes
2 = No

D) If this was session 10 (CBT10), did you have **participants complete a small card** on which they listed the benefits of not using marijuana and negative consequences of marijuana use?
1 = Yes
2 = No

E) If this was session 12 (CBT12), did you spend time addressing **termination issues** (i.e., encourage participants to discuss their feelings or thoughts about treatment completion)?
1 = Yes
2 = No

2) To what extent did you **assess the participants' use of marijuana** or other substances since the last session?

1……2……3……4……5
not at all a little somewhat considerably extensively

3) In your opinion, should any of the participants be considered for **removal from treatment** due to clinical deterioration?
1 = Yes If yes, list participants:_____
2 = No If yes, why?_____

4) To what extent did you discuss or address the participants' **current commitment to abstinence**?

1……2……3……4……5
not at all a little somewhat considerably extensively

5) To what extent did you attempt to **elicit self-motivational statements** from the participants?

1……2……3……4……5
not at all a little somewhat considerably extensively

6) To what extent did you attempt to focus on the participants' **ambivalence** about changing their level of marijuana use?

1……2……3……4……5
not at all a little somewhat considerably extensively

7) To what extent did you encourage the participants to make a **commitment to changing their marijuana use**?

1……2……3……4……5
not at all a little somewhat considerably extensively

8) To what extent did you discuss any **high-risk situations** the participants encountered since the last session and explore any coping skills used?

1……2……3……4……5
not at all a little somewhat considerably extensively

9) To what extent did you teach, model, rehearse, review, or discuss **specific skills** (e.g., marijuana refusal skills, enhancing one's social support network, or planning for emergencies and coping with relapse) during the session?

1……2……3……4……5
not at all a little somewhat considerably extensively

10) Did you do a **roleplay**?
1 = Yes
2 = No

11) To what extent did you encourage the participants to **anticipate any high-risk situations** that might be encountered before the next session and **formulate appropriate coping strategies** for such situations?

1……2……3……4……5
not at all a little somewhat considerably extensively

12) To what extent did you **develop one or more specific assignments** for the participants to engage in between sessions?

1……2……3……4……5
not at all a little somewhat considerably extensively

13) To what extent did you review the **participants' reactions** to last session's assignment?

1……2……3……4……5
not at all a little somewhat considerably extensively

14) To what extent did you **provide one or more specific assignments** for the participants to engage in between sessions?

1……2……3……4……5
not at all a little somewhat considerably extensively

15) To what extent did you **emphasize the importance of real life practice** of skills between sessions?

1……2……3……4……5
not at all a little somewhat considerably extensively

16) To what extent did you attempt to **keep the session focused** on prescribed activities (by redirecting dialog when it strayed off task or organizing the session so defined activities were covered)?

1……2……3……4……5
not at all a little somewhat considerably extensively

17) To what extent did you **communicate understanding** of the participants' concerns through reflective listening and comments?

1……2……3……4……5
not at all a little somewhat considerably extensively

18) To what extent did you respond to the participants with **empathy, warmth, and acceptance**?

1……2……3……4……5
not at all a little somewhat considerably extensively

19) To what extent did you discuss the availability and nature of **family support** for the participants' efforts in treatment?

1……2……3……4……5
not at all a little somewhat considerably extensively

20) To what extent did you **discuss termination** of the therapy (review the timing of termination, encourage participants to discuss their feelings or thoughts about termination)?

1……2……3……4……5
not at all a little somewhat considerably extensively

Additional Notes:_____
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_____ _____
Signature Date

Appendix 3. Supervisory Forms

Recommended Certification Guidelines
Criteria for Certification of CBT7 Therapists

Supervisory Rating Form
MET/CBT5 + CBT7 Supervisory Group Session Report

Recommended Certification Guidelines
Criteria for Certification of CBT7 Therapists

Prior to being considered for certification of their competency in CBT7 treatment, therapists must have

- Obtained certification in MET/CBT5
- Competently delivered *each* of the following sessions:

  _____ Session 10: Coping With Cravings and Urges To Use Marijuana
  and
  _____ Session 12: Managing Thoughts About Marijuana

- Competently delivered *at least one* of the following sessions:

  _____ Session 6: Problem Solving
  or
  _____ Session 9: Effective Communication

- Competently delivered *at least one* of the following sessions:

  _____ Session 7: Anger Awareness
  or
  _____ Session 8: Anger Management
  or
  _____ Session 11: Depression Management

Sessions should be audiotaped or videotaped and then reviewed by supervisors. Therapists must have obtained a skill rating of at least four ("adequate") on the five-point Likert scale on most (i.e., 75 percent) of the skills assessed in each of the four sessions delivered. For therapists to obtain certification, no more than a few skills (i.e., 25 percent) delivered in a particular session may receive a rating of less than four.

If a therapist is not certified to deliver a particular session, only that session must be reassessed until the therapist is eligible for certification in CBT7 treatment. After therapists have been certified in MET/CBT5 + CBT7, their supervisors are encouraged to occasionally review the audiotapes or videotapes to ensure continuing quality.

Supervisory Rating Form
MET/CBT5 + CBT7: Supervisory Group Session Report

Instructions
Follow the same instructions as those given for the Therapist Self-Rating Form. In addition, complete the skill-level section according to the following rating guidelines:

1. not done: The intervention was not delivered in that session.
2. poor: The intervention was presented but delivered with little therapeutic skill or competence.
3. fair: The intervention was delivered with some therapeutic skill or competence.
4. adequate: The intervention was delivered with reasonable clinical skill or competence.
5. well: The intervention was delivered well, with sufficient clinical skill or competence.

1 = MET/CBT5
2 = MET/CBT5 + CBT7
3 = MET/CBT5 + CBT7 + FSN

____ Makeup Session
____ Number of Participants

Participants_____
_____
Therapist_____
Date _____
Session #_____

1) What **topic** was covered in this session?

6 = CBT6, Problem Solving
7 = CBT7, Anger Awareness
8 = CBT8, Anger Management
9 = CBT9, Effective Communication
10 = CBT10, Coping With Cravings and Urges To Use Marijuana
11 = CBT11, Depression Management
12 = CBT12, Managing Thoughts About Marijuana

A) If this was session 6 (CBT6), did the therapist also cover the topic of **problem recognition**?
1 = Yes
2 = No

B) If this was session 7 (CBT7), did the therapist cover the topic of **relaxation training** with the group participants?
1 = Yes
2 = No

C) If this was session 9 (CBT 9), did the therapist **roleplay** both appropriate and inappropriate responses to receiving criticism?
1 = Yes
2 = No

D) If this was session 10 (CBT10), did the therapist have **participants complete a small card** on which they listed the benefits of not using marijuana and negative consequences of marijuana use?
1 = Yes
2 = No

E) If this was session 12 (CBT12), did the therapist spend time processing **termination issues** (i.e., encourage participants to discuss their feelings or thoughts about treatment completion)?
1 = Yes
2 = No

2) To what extent did the therapist **assess the participants' use of marijuana** or other substances since the last session?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

3) In your opinion, should any of the participants be considered for **removal from treatment** due to clinical deterioration?
1 = Yes If yes, list participants:_____
2 = No If yes, why?_____

4) To what extent did the therapist discuss or address the participants' **current commitment to abstinence**?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

5) To what extent did the therapist attempt to **elicit self-motivational statements** from the participants?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

6) To what extent did the therapist attempt to focus on the participants' **ambivalence** about changing their level of marijuana use?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

7) To what extent did the therapist encourage the participants to make a **commitment to changing their marijuana use**?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

8) To what extent did the therapist discuss any **high-risk situations** the participants **encountered** since the last session and explore any coping skills used?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

9) To what extent did the therapist teach, model, rehearse, review, or discuss **specific skills** (e.g., marijuana refusal skills, enhancing social support, or planning for emergencies and coping with relapse) during the session?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

10) Did the therapist do a **roleplay**?
1 = Yes
2 = No

Skill Level:

1……2……3……4……5
not done poor fair adequate well

11) To what extent did the therapist encourage the participants to **anticipate any high-risk situations** that might be encountered before the next session and **formulate appropriate coping strategies** for such situations?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

12) To what extent did the therapist **provide one or more specific assignments** for the participants to engage in between sessions?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

13) To what extent did the therapist review the **participants' reactions** to last session's assignment?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

14) To what extent did the therapist **emphasize the importance of real life practice** of skills between sessions?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

15) To what extent was it **difficult** for the therapist **to engage** the group?

1……2……3……4……5
not at all a little somewhat considerably extensively

16) To what extent did the therapist manage **disruptions to the group process** (e.g., using aggression, telling war stories, using excessive profanity)?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

17) To what extent did the therapist attempt to **keep the session focused** on prescribed activities (by redirecting dialog when it strayed off task or organizing the session so defined activities were covered)?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

18) To what extent did the therapist **communicate understanding** of the participants' concerns through reflective listening and comments?

1……2……3……4……5
not at all a little somewhat considerably extensively

19) To what extent did the therapist respond to the participants with **empathy, warmth, and acceptance**?

1……2……3……4……5
not at all a little somewhat considerably extensively

20) To what extent did the therapist discuss the availability and nature of **family support** for the participants' efforts in treatment?

1……2……3……4……5
not at all a little somewhat considerably extensively

21) To what extent did the therapist **discuss termination** of the therapy (review the timing of termination, encourage participants to discuss feelings or thoughts about termination)?

1……2……3……4……5
not at all a little somewhat considerably extensively

Skill Level:

1……2……3……4……5
not done poor fair adequate well

22) Rate the **quantity of participation** of this group.
3 = High
2 = Medium
1 = Low
0 = Silent

23) Rate the quality of participation of this group.
3 = High
2 = Medium
1 = Low
0 = No quality

Additional Notes:_____
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_____ _____
Signature Date

Appendix 4.

Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abusers

Nancy Angelovich, M.S.[1]
Tracy Karvinen, M.A.[2]
Suzie Panichelli-Mindel, Ph.D.[3]
Susan Sampl, Ph.D.[4]
Meleney Scudder, Psy.D.[4]
Janet Titus, Ph.D.[5]
William White, M.A.[5]

[1] Operation Parental Awareness and Responsibility (PAR), Inc.
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Abstract

Bridging the gap between clinical research and clinical practice in the treatment of adolescent substance abuse requires empirically validated therapies and technology transfer strategies that reflect an awareness of the realities and resource constraints of local treatment service providers. This article describes the management of cross-site and cross-intervention clinical issues in the Cannabis Youth Treatment (CYT) study, a multisite, randomized, clinical trial of five outpatient therapies. The methods used in the management of such clinical trials could play an important role in elevating the quality of adolescent substance abuse treatment as practiced in the field. This technology involves 1) defining and delineating clinically relevant subpopulations of clients, 2) developing research-supported manuals that define the theory, active ingredients, and procedures of treatment, 3) monitoring therapist adherence to manual-based therapy, 4) monitoring client responses to the procedures as they are implemented, 5) individualizing and refining the delivery of these manual-based therapies within the context of clinical supervision, and 6) conducting rigorous and sustained followup to determine the enduring effects of the interventions.

Carroll and her colleagues (1994) detailed the strategies used to implement and to protect the integrity of three manual-based therapies evaluated within Project MATCH, a multisite study of adult alcoholism treatment (Project MATCH Research Group, 1993). This paper takes a similar approach in describing cross-site clinical coordination procedures within the Cannabis Youth Treatment study, the largest multisite, randomized field experiment ever conducted of adolescent substance abuse treatment. More specifically, the paper details the common clinical infrastructure within which these therapies were implemented across the treatment sites.

It is our collective experience that therapies can fail in the transition from efficacy (outcomes under ideal circumstances) to effectiveness (outcomes in the real world of adolescent treatment), not because of flaws in the interventions themselves, but because of the absence of a sound foundation of clinical management upon which empirically validated interventions are replicated. The construction of stable clinical infrastructures within local treatment programs is as important to the future of adolescent treatment as the availability of research-validated therapies.

The Cannabis Youth Treatment Study

After declining in the 1980s, both licit and illicit drug use among adolescents rose in the 1990s. In 1996, cannabis use by adolescents (8th, 10th, and 12th graders) reached its highest peak in 12 years for reported lifetime use, past year use, and past month use (ISR, 1997). As cannabis abuse/dependence emerged as the leading cause for admission to substance abuse treatment (OAS, 1997), demands increased for research-validated treatments for cannabis-involved adolescents. In response to this need, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) of the U.S. Department of Health and Human Services (DHHS) funded the CYT study.

The CYT study is a multisite, randomized field experiment designed to test the efficacy of five promising outpatient treatment interventions for cannabis-abusing and cannabis-dependent adolescents. Its long-range goal is to provide validated and cost-effective models of intervention that can be widely replicated in local treatment agencies across the country. The study sites include Chestnut Health Systems in Madison County, Illinois (CHS–MC); the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation PAR (PAR) in St. Petersburg, Florida; and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. The sites represent both academic, research-oriented clinics (UCHC and CHOP) and community-based adolescent treatment programs (CHS–MC and PAR) (Dennis, Babor, Diamond, Donaldson, Goldley, Tims, et al., 1998; Herrell, Babor, Brantley, Dennis, et. al., 1999). The CYT study provides a test in geographically diverse environments of treatments that differ in theoretical orientation, delivery format and focus, and dose.

Between June 1998 and February 1999, 600 adolescents (approximately 150 per site) meeting the criteria presented in the *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition-Revised (DSM–IV) (American Psychiatric Association, 1994) for cannabis abuse or cannabis dependence were randomly assigned to one of three conditions, with a total of five conditions used across the four sites. The five conditions include:

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—5 individual/group sessions (MET/CBT5) (Sampl & Kadden, 2001)

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—7 individual/group sessions (MET/CBT5 + CBT7) (Webb, Scudder, Kaminer, & Kadden, 2002)

- Family Support Network (FSN) (Hamilton, Brantley, Tims, Angelovich, & McDougall, 2001) (FSN includes MET/CBT5 + CBT7 plus enhanced family supports: home visits, parent education classes, parent support groups)

- Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, 2001)

- Multidimensional Family Therapy (MDFT) (Liddle, in press).

At UCHC and PAR, adolescents were assigned to a five-session brief intervention (MET/CBT5) or to one of two other interventions that combine more extensive individual and group sessions (MET/CBT5 + CBT7 or FSN). At CHS–MC and CHOP, adolescents were assigned to the five-session brief intervention (MET/CBT5) or to one of two individual/family approaches (ACRA or MDFT). All study participants were assessed at intake and at 3 months, 6 months, 9 months, and 12 months. Treatment completion rates were in the 70-percent range, and followup rates through 9 months after treatment exceeded 95 percent (Titus et al., 1999; Godley, Diamond, & Liddle, 1999).

Methodological Challenges

There were three important challenges in conducting this multisite field experiment. The first was to ensure the integrity of each of the interventions being tested (Moncher & Prinz, 1991). Following what has been referred to as the "technology model" (Carroll et al., 1994; Carroll & Nuro, 1996; Carroll, 1997), workgroups led by a technical expert in interventions and a therapist coordinator (TC) responsible for cross-site supervision of that intervention took the following six steps to enhance its integrity:

- Defined and manualized the active ingredients of each therapy, including the frequency, intensity, duration, and sequencing, and indicated responses to the most common problems that occur during delivery of the intervention

- Conducted 15 to 25 hours of centralized, competency-based training for the therapists delivering the interventions and followed this by local certification of staff in each intervention

- Developed a therapist's skillfulness scale to serve as a cross-site measure of general therapeutic competence

- Developed a service contact log to measure therapists' adherence to each of the five interventions and to document the dosage and types of services provided to each client

- Taped and rated sessions for model fidelity (all tapes were rated as part of the cross-site supervision by an expert in the intervention until each therapist was certified, after which two tapes per therapist, per month, were reviewed and rated)

- Conducted weekly (1-hour onsite or telephone) individual supervision and weekly or bimonthly (60 to 90 minute) cross-site group supervision for each intervention.

These procedures helped enhance treatment differentiability (the delineation of the ingredients and procedures that distinguished each treatment from the other treatments) and treatment adherence (the assurance that the interventions [as delivered] maintained fidelity to the original manual-defined procedures) (Hoffart, 1994).

A second challenge involved controlling extraneous factors that could compromise interpretation of the treatment outcomes. To accomplish this, every effort was made to ensure that all general clinical procedures, other than those involved in the specific therapies, would be handled similarly across sites and interventions. This was done to minimize the ability of these contextual issues to unduly influence the evaluation of the experimental interventions and was achieved in two ways. First, staff of the CYT coordinating center conducted two site visits at each of the four service delivery sites to ensure that each site met baseline standards related to arenas such as research protocol compliance, accessibility and appropriateness of clinical space, clinical supervision structure, recruitment strategies, intake and service procedures, confidentiality procedures, crisis and safety net procedures, clinical documentation, data security and storage, and followup procedures. Second, the TCs for each intervention coordinated similar responses to issues that were not part of the specific interventions in monthly conference calls facilitated by the CYT coordinating center. Details of this latter process will be described shortly.

The third challenge was to enhance the external validity of the interventions (the generalizability of study findings) by ensuring that the interventions could be implemented as designed within the resource constraints of settings that currently provide the bulk of services to drug-involved adolescents. It was the goal of the CYT TCs to do everything possible in the CYT study to bridge the traditional gap between efficacy research conducted under experimental (ideal) conditions and effectiveness research conducted in field (real) settings. We wanted to document the kind of clinical infrastructures and the management of day-to-day clinical issues that might need to accompany these unique interventions if they were to achieve comparable results in the field.

The monthly conference calls among the TCs for each of the five interventions and the staff from the CYT coordinating center were particularly helpful in facing the latter two of these challenges. The purpose of these meetings was to define how sites would manage common clinical issues that were not a unique part of the experimental interventions but which, if not identified and controlled, might corrupt the evaluation of these interventions. We were concerned, for example, that if therapists in one intervention expelled adolescents from treatment (and the study) for arriving at a session high, while another site either allowed such adolescents to participate or rescheduled their sessions, differences in completion rates between these sites would reflect not the power or weakness of the interventions but contextual policies unrelated to the active ingredients of each intervention.

What follows is a synopsis of how common clinical issues were managed across the four treatment sites and across the five interventions being

tested. It is hoped that this discussion will provide researchers and treatment practitioners alike with insights into the importance of managing such contextual influences. The discussion also represents a snapshot of baseline clinical practices in adolescent substance abuse treatment in 1998 and 1999.

Issues in Clinical Management and Clinical Care

A. Clinical Infrastructure. A rather complex clinical infrastructure was required to effectively manage clinical activities across the four treatment organizations and the five treatments in the CYT study. The care taken in constructing this infrastructure was based on the assumption that there is a close relationship between the quality of clinical supervision and treatment efficacy (Holloway & Neufeldt, 1995).

There were three levels of clinical coordination and supervision in the CYT study. First, local clinical supervisors at each service site coordinated cross-intervention clinical issues and day-to-day clinical problem solving. Second, a therapist coordinator for each of the five interventions used in the CYT study provided onsite and cross-site clinical supervision of staff working in their particular intervention. This supervision occurred weekly during the period in which therapists were being certified and bimonthly following staff certification. Third, a TC at the CYT coordinating center facilitated cross-site and cross-intervention coordination and problem solving. The centerpiece of this cross-site clinical coordination was a monthly meeting at which the respective TCs met with the cross-site TC and research coordinator via a conference call to discuss cross-site clinical and research issues. Particular problems or procedural questions emerging from these discussions were sometimes also referred to the CYT executive committee (all of the principal investigators, the CSAT project officer, and other CSAT staff) for consultation or decision making. The CYT coordinating center validated that the cross-site clinical procedures developed through these processes were in place by conducting two monitoring visits to each of the CYT research sites during the course of the study (*CYT cooperative agreement,* 1999).

Many problems and issues (administrative, fiscal, research, clinical, ethical, legal) were addressed in this multitiered supervisory structure, but the major goals were to meet the methodological challenges noted earlier: ensuring the integrity of the interventions, controlling factors that could confound outcomes, and enhancing the generalizability of findings. Several steps were taken to achieve these goals.

All sites used the same research and service intake and clinical assessment/screening procedures, the same inclusion and exclusion criteria, and the same approach to randomization and waiting list management. To maximize transferability of findings to the field, exclusion criteria were limited to adolescents 1) who needed a higher level of care than outpatient treatment, 2) who presented for treatment with confirmed histories of drug dealing or violence (particularly predatory behavior patterns reflecting a high frequency, high intensity, and long duration), 3) whose psychiatric comorbidity was so severe as to render them inappropriate for the CYT interventions, and

4) whose primary drug of choice was not cannabis. Although the study focused on adolescents with a primary drug choice of cannabis, most adolescents entering the CYT study reported using other drugs in addition to cannabis. Although abstinence from all alcohol and drug use was a goal of the treatments in the CYT study, at admission, adolescents were asked to agree to evaluate their drug use and its effects on themselves and their families. Therapists across sites and interventions agreed that many adolescents' commitment to abstinence was something that should emerge out of the treatment process, not something that should be a precondition for entry into treatment.

Mechanisms to enhance clinical fidelity to the interventions used in the study included centralized training and booster training of clinical staff delivering the interventions, the videotaping or audiotaping of all sessions followed by the use of self- and supervisory-scored adherence measures to monitor skillful execution of the intervention, formal procedures to certify each therapist in the intervention, continued postcertification tape reviews to minimize therapist "drift," and regular cross-site group supervision led by an expert in the intervention.

A considerable portion of the monthly meeting of the CYT TCs was aimed at ensuring baseline clinical processes and data collection procedures were being handled consistently across the four sites. There were discussions of just about everything—from drug testing procedures to appropriate responses to clinical deterioration of a study participant. The monthly agenda included a site-by-site review of particular issues, such as the status of therapists' certifications and the quality of communication between sister sites (those delivering the same interventions), and an opportunity to discuss the general problems and issues encountered. Below are some of the cross-site clinical issues that were of major concern throughout the course of the study.

B. Staff Recruitment, Training, and Retention. Most of the therapists working on the CYT project were trained at the master's degree level or higher, and most had prior training and experience in addiction treatment. The research sites, like the practice field, varied in their use of full-time and part-time staff. Most sites felt there were advantages to having full-time therapists working on the project because that increased their availability to clients, provided greater flexibility in scheduling, and created a greater degree of personal investment in the project. In general, sites looked for individuals with good clinical skills whose overall clinical orientations were congruent with the intervention they were going to deliver. A particular effort was made to find staff who had a good working knowledge of child and adolescent development—a qualification not often found in those working with adolescent substance abusers (Kaminer, 1994). Staff were paid salaries that were at or slightly above the geographical norm for addiction therapists. None of the sites experienced any significant problems recruiting qualified staff.

In the course of the project, there were a total of 26 full-time and part-time clinical positions at the 4 CYT sites. Nine staff left the CYT project during

this period—two due to changes in the communities selected as service sites and the majority of the others due to a return to school, family relocation, or promotion. The highest turnover rate was among the case managers. Several things worked to enhance staff morale and retention on the CYT project: a conscious effort to build team cohesion, a knowledge of the potential importance of the research being conducted, the training and supervision opportunities, the opportunity for cross-site contact with peers working on the same intervention, and the flexibility of the individual sites regarding scheduling of part-time employees on the project.

Although considerable effort is made to ensure that conditions in clinical trials are equivalent to natural conditions in the field, there are several characteristics of clinical trials staff that make them somewhat different from those in mainstream practice. Staff who seek clinical positions in clinical trials are not scared away by the limited timeframe of employment on such a project, are often attracted by the intense nature of training and supervision such projects afford, and are not put off by the rigorous record-keeping generally required in such projects.

Strategies used for managing clinical continuity in the face of staff attrition included replicating the training that was provided to all therapists at the beginning of the CYT project, having a built-in transition/training period for entering staff, and using videotaped sessions of the current therapists to train new therapists.

The safety of staff working in the field was enhanced by hiring staff from the local community, providing inservice training on safety management and access to beepers and cellular phones, and the option of working in teams to visit areas that posed higher safety threats. Office-based safety issues were addressed by ensuring that other staff were present while sessions were being conducted and by providing walkie-talkies or silent alarms to signal other staff if assistance was needed. There were no major safety-related incidents experienced by the CYT project.

C. Client/Family Recruitment, Engagement, and Retention. The major barriers in recruiting, engaging, and retaining adolescents and their families were fairly consistent across the CYT project sites:

- Low adolescent/parent motivation for treatment involvement
- The perception that other problems in the family were more important than the drug experimentation of one child
- Parental substance abuse
- The parental view that smoking marijuana is not that big a deal
- Failure to attend due to lack of transportation or child care
- A marital or relationship breakup during the period of treatment involvement

- Inconsistent messages from the parents to the adolescent about the importance of involvement in counseling
- Relocation of the child during the course of treatment
- Parents having given up on efforts to change their child
- A general and pervasive sense of hopelessness about life (felt by both the parents and the adolescent).

Study participants were recruited by direct appeals to youth and parents through newspaper and radio public service announcements and strategically placed bulletin board posters. Staff also oriented local youth service professionals regarding how referrals could be made to the program and the nature of the various treatments that youth would be receiving. These visits and mailings included CYT information packets, business cards, and Rolodex inserts. There was some resistance to referring clients to the project when referral sources discovered that they could not control which intervention their clients would receive. Some were concerned that the five-session intervention would not provide an adequate level of service. After some education about the benefits of brief therapy in general, however, and the need to test such therapies in the substance abuse arena, most were willing to make referrals.

Of 690 adolescents referred to the CYT sites between May 1, 1998, and May 31, 1999, 38.6 percent were referred by criminal justice-affiliated agencies, 24.8 percent by families (7.6 percent of which came from a media promotion of the CYT project), and 15.2 percent by educational community health and human service agencies (Webb & Babor, 1999). An analysis of adolescents admitted to treatment in the CYT study (Tims, Hamilton, Dennis, & Brantley, 1999) revealed that 84.7 percent were age 15 or older, 38.1 percent were nonwhite, and 11.9 percent were female. The low rate of female admissions is attributable to at least two factors. The first involves the use of referral sources such as juvenile probation departments that serve predominantly male clients. The second factor is that, of those females referred to the CYT study, more than one-third presented with comorbid psychiatric disorders severe enough to exclude their participation in the study.

Client engagement was enhanced through five broad strategies. The first was to make the transition between the research staff (the equivalent of the intake staff in most agencies) and the clinical staff as personal as possible. When a therapist was not available to be introduced to the client/family by the research staff, the assigned therapist called the parents or the adolescent before the first appointment to introduce himself or herself, begin alliance building, and clarify any questions about treatment participation. All of the CYT interventions begin with an emphasis on empathy and skillful rapport building to build a strong therapeutic alliance and work through resistance related to the coercive influences that may have brought the adolescent to treatment.

The second strategy was for the therapist to speak for 5 to 10 minutes with any adolescent who had to wait more than 2 weeks to begin service (a delay sometimes caused by randomization and the cycles of starting new groups) to sustain his or her motivation for service involvement.

The third strategy was to remove as many environmental obstacles to treatment participation as possible by using geographically accessible service sites, providing assistance with transportation (that is, cab vouchers, bus tokens, picking adolescents up in the agency van), and providing or arranging child care. Case management, whether provided by therapists, case managers (in the FSN intervention), or even during the screening activities of the research staff, was an essential medium of engagement for those families whose lives were most chaotic at the point of initial contact with the CYT project. Every effort was made to link what could be learned in treatment with what could help the immediate crisis presented by the family. The CYT interventions shared the message, "We have something that could help with some of these problems and improve the quality of life for you and your child."

The fourth and most important strategy was to actively engage the adolescents and families by creating strong therapeutic alliances, expressing interest in their participation (e.g., by weekly phone prompts for participation), finding a goal that the adolescent and family were interested in working on, expressing optimism in their capacity to change, and persisting in family contacts during the earliest signs of disengagement. FSN intervention staff felt that home visits were very important in initiating and sustaining the involvement of the most treatment-resistant families.

The fifth strategy was to provide a warm, collaborative, adolescent- and parent-friendly environment (with informal but respectful hosting, providing pizza and sodas as part of the dinner-hour adolescent and parent meetings) and to provide specific incentives for involvement in treatment (help with very specific problems, fully subsidized treatment, and token prizes for homework completion).

D. Safety Net Procedures. Safety net procedures involve strategies for recognizing and responding to adolescents who before or after entering outpatient care were thought to be in need of a higher level of care or allied services. We anticipated and experienced four scenarios that required such safety net procedures. The first involved emergency situations that might arise related to an adolescent's drug use during the course of the study. All parents were provided a laminated card listing signs of acute intoxication and oriented to procedures that could be used to respond to an emergency. The second scenario occurred when adolescents underreported the frequency and intensity of their drug use at intake but disclosed it after they were randomized and admitted to one of the therapies. The third scenario involved the frequency and intensity of use escalating after the adolescent had been admitted to outpatient treatment. The fourth scenario occurred when an adolescent's mental health status deteriorated following admission, particularly where such deterioration posed the threat of harm to himself or herself or others. Safety net procedures were established at

all four sites that 1) ensured the periodic reassessment of the status of use and the appropriateness of the level of care to which clients were assigned, 2) ensured the availability and use of supervisory supports to formally reevaluate changes in clients' status and care needs, and 3) facilitated, when needed, moving an adolescent to a more structured and intense level of care or the addition of collateral services. Where alternative or additional services were thought to compromise evaluation of the effect of the CYT intervention, the adolescent and family were provided the additional services but the adolescent was no longer included in the study.

E. Concurrent Services. The exclusion of adolescents with severe psychiatric illness from the CYT study does not mean that all adolescents with psychiatric comorbidity were excluded from the CYT study. The majority of adolescents and families admitted to the CYT study presented with multiple problems, and the rate of psychiatric comorbidity of the adolescents admitted to the study was quite high. Forty-two percent met the criteria for attention deficit/hyperactivity disorder, 55 percent met the criteria for conduct disorder, and 29 percent presented with multiple symptoms of traumatic stress (Tims, Hamilton, Dennis, & Brantley, 1999). Those adolescents who were referred for more intense services prior to randomization and who were not included in the CYT study were most likely to be excluded because they presented a high risk of harm to themselves or others. (These risks were identified through the participant screening form completed at intake and through the assessment instrument [GAIN] [Dennis, Webber, White, et al., 1996] and the interviews that were part of the intake process at all of the CYT service sites.)

The multiple problems presented by the CYT adolescents and their families raised an important clinical and research issue: How to respond to the clinical needs they presented without contaminating (through concurrent service involvement) the evaluation of the particular interventions in the CYT study. This problem was complicated further by the referral patterns of the agencies that linked adolescents with the CYT project. Acutely aware of the number and complexity of the problems many of these adolescents presented, many of these referral sources used a shotgun approach—simultaneously referring the adolescent and family to multiple treatments, hoping that the cumulative dose of services would have some positive effect on the child and family. These problems diminished through education of and negotiation with referral sources. It was a policy of the CYT study that adolescents would not be allowed to remain in the study if they were receiving concurrent treatment whose primary focus was the problem of substance abuse or if they were receiving services whose impact was judged by the local staff to inordinately confound the impact of the CYT intervention being provided. However, no adolescent had to be excluded from the study for such concurrent service involvement. Several adolescents who were treated simultaneously for collateral problems (e.g., being medicated for hyperactivity or depression) were allowed to enter and remain in the CYT study because the focus of the concurrent services was not on substance abuse or dependency.

F. Session Management. Efforts were made to ensure that issues related to the management of sessions that were not unique to the particular interventions would be handled in reasonably consistent ways across the sites. Where procedures were not the same, they were reviewed to ensure the differences would not confound outcomes. These discussions included how to respond to lateness, missed sessions, the criteria for dropping cases, intoxication, contraband, disruptive behavior, preexisting relationships between members, and a group session at which only one member is present.

Lateness was handled by degree, by ensuring either that the client got the minimal dose for that session or that the session was rescheduled. Missed sessions were rescheduled or, in the case of group interventions, provided as an abbreviated makeup session prior to the next scheduled session. (All services across the five modalities were expected to be completed within 14 weeks of the time of the first therapy session, with local TCs reviewing and approving any exceptions to this rule.)

All programs made intoxication and possession of contraband grounds for exclusion from that particular session and a flag for reassessment of the appropriateness of the current level of care. (While rare episodes of an intoxicated youth arriving for services did occur, these episodes were clinically managed without excluding the adolescent from continued service.) Only one adolescent per family was included in the CYT study, and preexisting relationships between participants in the group modalities were reviewed to determine whether the prior history would undermine or enhance treatment. A group with only one member present was conducted in a 30- to 45-minute individual format covering the material that was scheduled for presentation. If an adolescent failed to appear for a family session, the session was conducted without the adolescent.

The TCs collectively sought and implemented general strategies that could enhance the effectiveness of sessions for all of the CYT therapies. Strategies that served to minimize problems and enhance session effectiveness included formalizing, posting, and consistently enforcing group/family norms on such issues as dress (banning drug/gang symbols on clothing) and language (profanity, drug argot). In the group interventions, the closed group structure made it particularly important to guard against negative influences within the peer cultures that evolved. A final issue was the appropriate level of contact between therapists and adolescents outside the intervention. The TCs decided that such contact should be minimized so as not to contaminate model fidelity by altering dose. More specifically, it was agreed that all extra-session contact should be responded to within the therapeutic framework of the particular intervention, channeled into upcoming sessions, documented, and brought to supervisors for review.

G. Gender and Cultural Adaptations. While there is significant momentum toward the development of standardized, empirically supported, and manual-based treatments (Wilson, 1998; Carroll, 1997), there is a simultaneous call for the refinement of standardized treatment that includes gender and cultural relevance and effectiveness (Orlandi, 1995). All of the CYT therapists noted making changes in their delivery of the

manual-based treatments that were based on gender, cultural, and socioeconomic status (SES) appropriateness. Therapists in group interventions explicitly noted diversity issues in the group and incorporated respect for diversity into the ground rules established at the beginning of each group. The most frequently mentioned adaptations included:

- Changing the language of the session to reflect cultural or geographical norms
- Adding items to some worksheets to make them more applicable to urban youth
- Providing special writing and reading assistance to address illiteracy
- Slowing the pace and adding repetitions of key ideas to accommodate learning impairments
- Developing examples and illustrations of key points that had greater gender, cultural, and SES relevance.

Therapists emphasized it was not the content of interventions that had changed; there were subtle changes in the way that content was framed or delivered.

H. Case Mix Issues. Therapists involved in the group interventions (MET/CBT5, MET/CBT5 + CBT7, FSN) also decided to monitor closely client mix issues according to gender, ethnicity, and other important dimensions. There was an effort to identify any potential iatrogenic effects of randomization (e.g., harassment, scapegoating, or other predatory targeting of a vulnerable group member by other group members) and to actively manage potential negative effects of group support for antisocial behavior (Dision, McCord, & Poulin, 1999). This was managed primarily by establishing and enforcing norms for group sessions.

I. Mutual Aid and Peer Support Groups. In contrast to Project MATCH, a 12-step facilitation therapy was not included in the CYT study, and there was some variation in the philosophies of the 5 interventions related to the desirability of mutual aid involvement by cannabis-involved adolescents. The ACRA, MDFT, and MET/CBT interventions do not directly encourage affiliation with addiction recovery support groups, but they do frame such involvement positively if the adolescent is already involved in such a group or self-initiates involvement during the course of treatment. FSN, while strongly encouraging parents to participate in Al-Anon, does not directly encourage adolescent clients to affiliate with Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Information on local mutual support groups is provided simply as one of many community resources. There was more of an emphasis in all the CYT interventions on involvement in drug-free prosocial activities in general than on addiction recovery support group involvement.

J. Ethical Issues. The TC meetings also provided a venue to discuss and formulate responses to some of the complex ethical and legal issues that can arise in the treatment of adolescent substance abuse (White, 1993). Considerable time was spent discussing questions such as:

- What are the boundaries of confidentiality regarding disclosure of information about an adolescent to his or her parents?
- Do parents have a legal/ethical right to the results of their child's urine tests?
- What circumstances would constitute a duty to report or duty to intervene?
- What obligations, if any, do therapists have in responding to an adolescent's disclosures of past or planned criminal activity?
- How should therapists respond to reports of abuse of adolescents by a parent or to failures by child protection agencies to intervene to ensure the safety of the adolescent?

Discussion

Carroll and colleagues (1994, 1996, 1997) are to be commended for helping transfer the technology model of psychotherapy research to addiction treatment outcome studies. The CYT study greatly benefited from the earlier experience of Project MATCH in the use of this model. This paper has described a structure (the interface between a cross-site and cross-intervention TC group and the CYT executive committee) and a process (monthly meetings of all the TCs and monitoring visits at each CYT study site) that were used to control contextual elements surrounding the experimental interventions. Our goal was to hold these contextual elements constant across the interventions in order to enhance our ability to measure the differences the experimental interventions produced on outcome measures. We wanted differences in outcomes to reflect differences in the interventions themselves and not factors incidental to the interventions.

While there were major research design elements (consistency in clinical data collection instruments and procedures, inclusion and exclusion criteria, and followup procedures) that helped control such variance across sites and interventions, we also sought to identify more subtle areas of potential contamination of the study. By generating consistent cross-intervention procedures to respond to lateness, missed sessions, disruptiveness, intoxication, and concurrent participation in other services, we were able to ensure a consistent and a more precise definition of the dose and type of services provided in, and collateral to, each intervention. By developing and monitoring safety net procedures across the sites and interventions, we were able to ensure timely and appropriate responses to the placement of a client in an inappropriate outpatient modality who needed a higher level of care and to respond to acute episodes of clinical deterioration that warranted a similar change in the level of care. We found that the

collaborative work of the TCs helped enhance the methodological rigor of the CYT study and helped establish a sound clinical infrastructure upon which each of the interventions was tested.

There are many aspects of the clinical management of the CYT project other than the efficacy of the particular interventions used that may have wide applicability to the field of adolescent substance abuse treatment. It is our view that many of the procedures to provide overall clinical management of randomized field trials have great clinical utility and are likely to become future baseline clinical practices in the treatment of adult and adolescent substance abuse disorders.

The technology model that, to date, has been used primarily as a means of ensuring methodological rigor in multisite field trials seems to us to have enormous advantages for enhancing the quality of treatment and should be studied for potential adaptation to mainstream clinical practice. Those looking for ways to enhance the quality of adolescent substance abuse treatment would be well served to explore how the elements of this model could become part of the future definition of treatment as usual. Parents seeking help to address the substance abuse-related problems of their son or daughter ought to be able to expect that the theory behind the treatments they are offered can be articulated and that their active ingredients can be defined. They should further be able to expect that these treatments have some degree of scientific support for their effectiveness and that they will be delivered in a manner consistent with procedures whose effectiveness has been validated.

Increased demands for such accountability and fidelity by parents, policy makers, and funding agencies will likely make manual-based therapies the rule in the future, along with the training and adherence measures that accompany them. The technical aspects of cross-site clinical management of the CYT project have much to offer the field as a whole. The use of standardized assessment instruments that are capable of providing comprehensive assessment and treatment planning data should become a requirement of all adolescent treatment programs in the next decade. We further commend the use of central (and booster) training, videotaping and adherence ratings as standard practices in supervision, and cross-site supervision as marvelous tools for training and professional development. Finally, we believe that rigorous followup (monitoring, feedback, and, where indicated, early reintervention) should move from the realm of clinical research to being an expectation, if not a requirement, of mainstream clinical practice. The idea of providing services without measuring outcomes will be incomprehensible in the very near future, and the technology to perform this task is rapidly emerging. Morale among staff working in the CYT project remained high, in part because of the near universal belief in the historical importance of this study and the climate of excitement and discovery that permeated the project. We believe that small field-based experiments to answer critical clinical questions, opportunities for cross-site sharing, and the opportunity to work on papers and presentations can similarly contribute to staff morale within local service organizations. We believe this milieu of curiosity, discovery, and contribution is transferable

and sustainable in natural clinical settings. Routine outcome monitoring and field-based experiments, like the other items in this discussion, must simply be moved from the arena of clinical research to the arena of standard clinical practice. This transfer of technology from the research environment to the clinical practice environment, however, will not be simple.

If there is a single weak link in the current practice of addiction treatment that will slow this technology transfer, we believe it is in the arena of clinical supervision. Comprehensive assessments, science-guided treatment planning, empirically validated and manual-based therapies, regular adherence measurement and monitoring, using clients' response-to-treatment data to individualize and refine standard interventions, and rigorous posttreatment followup (and early reintervention, where called for) all flow from the clinical infrastructure at the core of which is a clinical supervisor. If we can elevate the quality of clinical supervision in the field—the selection, training, and support of clinical supervisors to do true clinical supervision—to that of clinical supervision in controlled clinical trials, we will be able to channel knowledge from clinical research to clinical practice.

Conclusions

Clearly defining the demographic and clinical characteristics of client populations, presenting the active ingredients in a manual format and procedures inherent in particular treatments for those populations, monitoring therapists' adherence to such procedures, controlling contextual influences that can influence treatment outcomes, and conducting rigorous and sustained followup to determine clients' responses to particular interventions collectively hold great promise in moving the treatment of adolescent substance abuse from the status of a folk art to that of a clinical science. The technologies used to build this science may themselves offer great potential in enhancing the quality of adolescent substance abuse treatment programs if they can be adapted for routine use in the clinical setting. The CYT study confirms the importance that these new tools can and will have in the future clinical management of adolescent substance abuse treatment.

References

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

Cannabis youth treatment (CYT) cooperative agreement: 1999 site visit protocol. (1999). Bloomington, IL: Chestnut Health Systems.

Carroll, K. M. (Ed.). (1997). *Improving compliance with alcoholism treatment.* National Institute on Alcohol Abuse and Alcoholism Project MATCH Monograph Series. Volume 6. NIH Pub. No. 97–4143. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

Carroll, K. M., Kadden, R. M., Donovon, D. M., Zweben, A., & Rounsaville, B. (1994). Implementing treatment and protecting the validity of the independent variable in treatment matching studies. *Journal of Studies on Alcohol* (Suppl. 12), 149–155.

Carroll, K. M., & Nuro, K. F. (1996). *The technology model: An introduction to psychotherapy research in substance abuse.* Yale University Psychotherapy Development Center, Training Series No. 1. Sponsored by the National Institute on Drug Abuse.

Dennis, M. L., Babor, T., Diamond, G. C., Donaldson, J., Godley, S., Tims, F., Chirkos, T., Fraser, J., French, M. T., Glover, F., Godley, M., Hamilton, N., Herrell, J., Kadden, R., Kaminer, Y., Lennox, R., Liddle, H., McGeary, K. A., Sampl, S., Scott, C., Titus, J., Unsicker, J., Webb, C., & White, W. L. (1998). *Treatment for cannabis use disorders general research design and protocol for the cannabis youth treatment (CYT) cooperative agreement.* Bloomington, IL: Chestnut Health Systems.

Dennis, M. L., Webber, R., White, W., Senay, E., Adams, L., Bokos, P., Eisenberg, S., Fraser, J., Moran, M., Ravine, E., Rosenfeld, J., & Sodetz, A. (1996). *Global appraisal of individual needs (GAIN), Vol. 1: Administration, scoring, and interpretation.* Bloomington, IL: Chestnut Health Systems.

Dision, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist, 54*(9), 755–764.

Godley, S. H., Diamond, G., & Liddle, H. (1999, August). *Cannabis youth treatment study treatment models: Principles, interventions, mechanisms.* Paper presented at the 107th Annual Convention of the American Psychological Association, Boston.

Godley, S. H., Meyers, R. J., Smith, J. E., Karvinen, T., Titus, J. C., Godley, M. D., Dent, G., Passetti, L., & Kelberg, P. (2001). *The adolescent community reinforcement approach for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 4.* DHHS Pub. No. (SMA) 01–3489. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Hamilton, N. L., Brantley, L. B., Tims, F. M., Angelovich, N., & McDougall, B. (2001). *Family support network for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 3*. DHHS Pub. No. (SMA) 01–3488. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Herrell, J., Babor, T., Brantley, L., Dennis, M., Diamond, G., Donaldson, J., Godley, S., Hamilton, N., Liddle, H., Tims, F., Titus, J., & Webb, C. (1999, August). *Treatment of adolescent marijuana abuse: A randomized clinical trial. A cooperative agreement funded by the Center for Substance Abuse Treatment.* Paper presented at the 107th Annual Convention of the American Psychological Association, Boston.

Hoffart, A. (1994). Use of treatment manuals in comparative outcome research: A schema-based model. *Journal of Cognitive Psychotherapy: An International Quarterly, 8*(1), 41–54.

Holloway, E., & Neufeldt, S. (1995). Supervision: Its contribution to treatment efficacy. *Journal of Consulting and Clinical Psychology, 63*(2), 207–213.

Institute for Social Research (ISR). (1997). *Monitoring the Future Study.* Ann Arbor, MI: University of Michigan.

Kaminer, Y. (1994). *Adolescent substance abuse: A comprehensive guide to theory and practice*. New York: Plenum Medical Book Company.

Liddle, H. A. (in press). *Multidimensional family therapy for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 5.* DHHS Pub. No. (SMA) 02–3660. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Moncher, F., & Prinz, R. (1991). Treatment fidelity in outcome studies. *Clinical Psychology Review, 11,* 247–266.

Office of Applied Studies (OAS). (1997). *National admissions to substance abuse treatment services. The Treatment Episode Data Set (TEDS) 1992–1995.* (Advanced Report No. 12, prepared by B. Ray, R. Thoreson, L. Henderson, & M. Toce). Rockville, MD: OAS, Substance Abuse and Mental Health Services Administration.

Orlandi, M. A. (Ed.). (1995). *Cultural competence for evaluators.* Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Project MATCH Research Group. (1993). Project MATCH: Rationale and methods for a multisite clinical trial matching alcoholism patients to treatment. *Alcoholism: Clinical and Experimental Research, 17,* 1130–1145.

Sampl, S., & Kadden, R. (2001). *Motivational enhancement therapy and cognitive behavioral therapy for adolescent cannabis users: 5 sessions, Cannabis Youth Treatment (CYT) Series, Volume 1*. DHHS Pub. No. (SMA) 01–3486. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Tims, F., Hamilton, N., Dennis, M., & Brantley, L. (1999, August). *Characteristics and problems of adolescent marijuana users in treatment.* Paper presented at the 107th Annual Convention of the American Psychological Association, Boston.

Titus, J., Dennis, M., Diamond, G., Godley, S., Babor, T., Donaldson, J., Herrell, J., Tims, F., & Webb, C. (1999, August). *Treatment of adolescent marijuana abuse: A randomized clinical trial. Structure of the cannabis youth treatment study.* Paper presented at the 107th Annual Convention of the American Psychological Association, Boston.

Webb, C., & Babor, T. (1999, August). *Cannabis youth treatment study: Referral sources.* Paper presented at the 107th Annual Convention of the American Psychological Association, Boston.

Webb, C., Scudder, M., Kaminer, Y., & Kadden, R. (2002). *The motivational enhancement therapy and cognitive behavioral therapy supplement: 7 sessions of cognitive behavioral therapy for adolescent cannabis users, Cannabis Youth Treatment (CYT) Series, Volume 2.* DHHS Pub. No. 02–3659. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

White, W. (1993). *Critical incidents: Ethical issues in substance abuse prevention and treatment.* Bloomington, IL: Chestnut Health Systems.

Wilson, G. T. (1998). Manual-based treatment and clinical practice. *Clinical Psychology: Science and Practice, 5*(3), 363–375.

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Hamilton, N. L., Brantley, L. B., Tims, F. M., Angelovich, N., & McDougall, B. *Family Support Network for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 3*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. BKD386

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