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**

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

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

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

**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* (Samp & 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
Session 1: MET1—Motivation-Building Session

Key Points:

• Build rapport with the client.

• Familiarize the client with what he or she can expect from treatment.

• Begin the process of assessing and building the client’s motivation to address his or her marijuana problem.

• Review the personal feedback report with the client.

Delivery Method: MET-focused individual therapy

Session Phases and Times:

1. Rapport-building and orientation to treatment (20 minutes)
2. Review of PFR and reactions to it (30 minutes)
3. Summarization of today’s session and preparation for next session (10 minutes)

Time: 1 hour total

Handouts:

• Two copies of the client’s personalized feedback report
• A Guide to Quitting Marijuana brochure
• An orientation sheet entitled Welcome!

Materials:

• A pocket folder

Procedural Steps

**Phase 1: Building Rapport.** This is an extremely important part of the treatment, during which the therapist and client first get to know each other. The goal is to create the feeling that the therapy sessions will be safe and supportive.

The therapist should begin by introducing himself or herself and then briefly explain the purpose of the first meeting—i.e., to become acquainted with the client and to give the client some information and feedback. The therapist may indicate that he or she has learned a bit about the client from information obtained during the intake or referral process or from the research staff but finds it most helpful to hear it directly from the client.
Here is the suggested discussion sequence for the rapport-building phase of the session:

1. Start with some casual conversation and a review of demographic facts, and attempt to learn a bit more about the client. For example, you can talk about whether the client is in school and, if so, in what grade; his or her living situation (where and with whom); and whether he or she has a job. This discussion should be fairly general and brief in order to leave enough time for the remainder of the session.

2. Ask an open-ended question about what led to the client’s involvement in marijuana treatment, as this will most likely present opportunities to initiate some of the MET strategies described earlier in this treatment manual. Try to include discussion about the following:
   - How the marijuana use first started
   - The extent of recent use
   - Whether there have been any previous attempts at quitting
   - What the client hopes to gain from treatment.

**Phase 2: Orientation to Treatment.** Give the client a copy of the Welcome! orientation sheet, which introduces the client to the treatment, and summarize the main points. You do not need to read it word for word.

Give the client the Guide to Quitting Marijuana brochure, and encourage the client to read the brochure before the next session. The Guide to Quitting Marijuana was produced by the Drug and Alcohol Research Centre, Sydney, Australia, and is available from Lighthouse Publications at:

702 W. Chestnut Street  
Bloomington, IL 61701  
Telephone: 888–547–8271  
Voice: 309–829–1058, x 3414  
Fax: 309–829–4661  
Web site: www.chestnut.org/li/publications  
E-mail: cschwartz@chestnut.org

Ask the client to bring the folder to each session because you will be providing additional information to add to it.
Welcome!

What You Can Expect From Us

Help for your marijuana problem. Treatment consisting of five sessions, covering a 5 to 8 week period. First you’ll have two individual sessions, then three group sessions. The sessions are designed to give you support and information about coping and to help you with marijuana-related problems. In the group sessions, you’ll get a chance to practice some coping skills and get feedback from other program clients.

Effective treatment. Delivered by a competent therapist. Your therapist is ________________________________.

Confidential treatment. What you tell us in treatment is confidential, meaning that we cannot tell anyone what you said without your permission, with the exception of those people described on the consent form. However, if you tell us that you are going to harm yourself or another person, or tell us about child abuse or neglect, we are required by law to inform those who can obtain help for you or for others.

What We Ask From You

Attendance. We ask that you come on time to all of your scheduled appointments. If you must cancel, we ask that you call the treatment program number (____-______) so that your therapist can be notified ahead of time and can call you to reschedule.

A clear head. We ask that you not use any drugs or alcohol on days when you have an appointment with your therapist. We believe that you will be able to benefit most from this program if you are not under the influence during your sessions.

Completion of treatment. We hope that you will come to all of your scheduled sessions. If, however, you ever consider leaving treatment early, we ask that you discuss this with your therapist as soon as possible.
Review of the Personalized Feedback Report

The therapist should give the client a copy of his or her PFR and lead the client through a systematic review of it. The therapist and the client should have their own copies of the PFR to review together to increase the collaborative nature of this process. The PFR included in this manual illustrates all possible items that could appear on a PFR. The client’s PFR will include some subset of the illustrated items, based on the client’s responses during the intake or research assessment.

The PFR is most useful for developing motivation when the client is given the opportunity to elaborate on each point. For example, as the therapist and client are reviewing the problem list section of the PFR, the therapist might say:

I know you’ve already told me some of the problems marijuana has been causing in your life [during the rapport-building phase of the session]. As we go over this list, why don’t you tell me some more about each of these problems, like the first problem: In what ways has marijuana led to ‘missing work or classes’?

The main task for the therapist is to listen to the client and respond with empathic reflection. Remember that the purpose of the PFR is not to do an initial assessment: The client already provided much information about his or her background and demographics in the initial assessment. If the therapist finds that the focus shifts to asking questions for which the solicited response is basic information, the PFR review is not serving the intended purpose. Instead, the therapist needs to focus on the MET processes described earlier (i.e., expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy). The PFR provides the raw material for engaging in a discussion that employs these techniques. If this therapy session is performed as intended, the therapist is likely to find that by the end of the session, he or she has a general picture of the client’s current life situation and a real understanding of the client’s thoughts and feelings about making a change in his or her marijuana use.

Sometimes clients may respond to the PFR review by attempting to argue about the validity of the items on their personal report (e.g., “I didn’t say smoking pot was causing me money problems!”). In such cases, do not try to debate the client with replies such as, “You must have checked off something like that, or it wouldn’t be on the report!” or “Well, you must pay for the pot in some way!” Instead, maintain a nondefensive tone, acknowledge that the client knows best what areas of his or her life have and have not been affected by marijuana use, and move on to the next item.

In keeping with the general recommendations for using this therapy, therapists again are encouraged to use open-ended questions rather than closed-ended questions. For example, “Did you say you used marijuana in unsafe situations?” is a closed-ended question that invites the potential to
disagree with the PFR item. Saying “Tell me about using in unsafe situations” invites elaboration and discussion.

Therapists may find that some sections of the PFR are especially conducive to motivational interviewing. For example, with a number of clients, the problems and the reasons for quitting sections may be especially likely to induce the client to explore his or her ambivalence about smoking marijuana. Therapists may adjust the relative emphasis on sections of the PFR to accentuate those sections that produce constructive discussion for any given client. For example, if a client seems especially interested in describing his or her reasons for quitting, the therapist may choose to spend extra time focusing on that area.

Note that the PFR review is expected to take approximately 30 minutes. This allows for quite a bit of discussion and related comments. Use double-sided reflections, develop discrepancy, and employ other MET strategies where relevant. Reviewing the PFR provides an excellent opportunity to explore the client’s ambivalence and to begin developing motivation for change. After reviewing the entire PFR, ask the client about his or her reactions to it, and listen with empathy.

**Phase 3: Session Summary.** In the final portion of the session, summarize the main points that you heard the client saying. Ask the client about his or her current readiness for change. Some clients are ready to verbalize the goal to change at this point. However, if a particular adolescent is not feeling ready to set a goal for change, the therapist should not pressure the client into doing so.

The following recommendations apply to helping those clients who do verbalize the goal to change:

If the client says that he or she wants to quit or reduce his or her marijuana smoking, ask what might help him or her to achieve that goal. Many clients may spontaneously come up with some ideas, such as asking friends to help them or not buying any more marijuana. Reinforce any such statements. If they are unable to come up with any ideas, help them do so. For example, say that some people find it helpful to stay away from friends who use, and ask if they think this would be helpful for them. Some of these ideas may flow directly out of the PFR discussion. Help them develop a plan regarding any remaining marijuana they have. Some clients may say that they are going to finish smoking the marijuana that they have left in their possession, while others may be comfortable disposing of it (giving it away, flushing it, etc.).

Many clients may not yet be willing to make a commitment to abstinence. Whether the client plans to quit or reduce use at this point, tell him or her that you’ll continue discussing this issue during the next session. Ask the client what today’s session has been like for him or her. Set up an appointment to meet again next week, and write it down on an appointment card.
This example of the PFR contains every possible PFR item. The PFR for any given client will contain only the items that the client endorsed during the initial assessment.

Therapist ________________________
Client ________________________

Personalized Feedback Report (PFR)

This report summarizes some of the information that you gave us in your interview on ___/___/____.

We want to give you an opportunity to review what you’ve told us and make any changes or additions. As you and I work together in reviewing and discussing this specific personal information, we can help you develop a program and strategies for dealing with marijuana that fit your individual needs.

Primary Substances

You reported that your favorite substance to use was____________________ and that you needed treatment for _____________________________.

You told us you first used alcohol or drugs at age ____ and have been smoking marijuana for ____ years. In the past year, you told us you had used ______________________. You have been in substance treatment ____ times before.

Extent of Use

In the past 90 days, you smoked marijuana on _____ of those days, with most being ____ hits over a ___ hour period. This places you in the _____ percentile relative to other adolescents age ___ to ___ in America.

In the past 90 days, you drank alcohol on _____ of those days, with the heaviest drinking episode being ____ drinks over a ___ hour period. This places you in the _____ percentile relative to other adolescents ages ___ to ____ in America.

In the past 90 days, you reported that you used other drugs, including ___________________________, on ___ days. In the past week you reported that you (had/had not) tried to quit (and that when you did you had the following problems: ____________________________) [List could include moving and talking much slower than usual; yawning more than usual; feeling tired; having bad dreams that seem real; having trouble sleeping (sleeping too much or trouble staying asleep); feeling sad, tense, or angry; feeling really nervous or tense; fidgeting, wringing your hands, or trouble sitting still; having shaky hands; having convulsions or seizures; feeling hungrier than usual; throwing up or feeling like throwing up; having diarrhea; having muscle aches; having a runny nose or eyes watering more than usual; sweating more than usual; having your heart race or goose bumps; having a fever; seeing, feeling, or hearing things that are not real;]
Problems

You indicated that your use of marijuana, alcohol, and/or other substances had caused you the following kinds of problems:

• You did not meet your responsibilities at home, school, or work.
• You used in situations where it was unsafe for you.
• Using caused you to have repeated problems with the law.
• You kept using even though it was causing you to get into fights.
• You had to use more to get the same high.
• You had withdrawal symptoms when you tried to stop.
• You used for longer than you wanted to.
• You have been unable to cut down or stop using.
• You spent a lot of time getting or using marijuana, alcohol, or other substances.
• Using led you to give up activities or caused problems at home, school, or work.
• You have kept using despite medical or psychological problems.

As you reflect on the consequences to your life of smoking marijuana, what would you add?

Reasons for Quitting

You said the main reason you came to treatment was ______________________ ______________________ . We showed you a list of personal reasons for quitting marijuana, and you said that you wanted to quit:

• To show myself that I can quit if I really want to.
• To like myself better.
• So that I won’t have to leave social functions or other people’s houses.
• To feel in control of my life.
• So that my parents, girlfriend, boyfriend, or another person I am close to will stop nagging me.
• To get praise from people I am close to.
• Because smoking marijuana does not fit in with my self-image.
• Because smoking marijuana is less “cool” or socially acceptable.
• Because someone has given me an ultimatum.
• So that I will receive a special gift.
• Because of potential health problems.
• Because people I am close to will be upset if I don’t.
• So that I can get more things done during the day.
• Because my marijuana use is hurting my health.
• Because I will save money by quitting.
• To prove I’m not addicted.
• Because there is a drug testing policy in detention, probation, parole, or school.
• Because I know others with health problems caused by marijuana.
• Because I am concerned that smoking marijuana will shorten my life.
• Because of legal problems related to my use.
• Because I don’t want to embarrass my family.
• So that I will have more energy.
• So my hair and clothes won’t smell like marijuana.
• So I won’t burn holes in clothes or furniture.
• Because my memory will improve.
• So that I will be able to think more clearly.

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

You also told us about several other problems that might be caused or made worse by your marijuana, alcohol, or other drug use. These include:

• The health problems you reported.
• The emotional problems you reported.
• Being bothered by upsetting memories.
• Having problems paying attention or controlling your behavior.
• The family problems you reported.
• Arguments, and problems you had with your temper.
• Being physically, sexually, or emotionally hurt.
• Doing things that were illegal.
• Getting in trouble at school.
• Getting in trouble at work.

Pattern of Use

You told us that the place(s) where you typically use marijuana, alcohol, and other drugs is/are:

• At home
• At someone else’s home
• At a party/bar
• At work
• At school
• At a dealer’s house
• Outdoors
• In a car
• Somewhere else (__________________________________________)
and that you typically use it with:

- No one else, alone
- Your romantic/sexual partner
- Family
- Friends
- A club or gang
- Coworkers
- Classmates
- A running partner (someone you regularly do drugs with)
- A drug dealer/pusher
- Someone else (____________________________________________)

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

Situational Confidence

You told us that you thought you could avoid using alcohol or drugs:

- At home
- At school or work
- With your friends
- When everyone around you was using them

You also told us that you (had quit and were _______% sure you could stay abstinent/you had not quit yet but were _______% sure you could quit).
Session 2: MET2—Goal-Setting Session

Key Points:

- Review progress, thoughts, and reactions since session 1.
- Collaborate on setting a treatment goal or goals for the remaining treatment sessions.
- Introduce the concept of functional analysis.
- Prepare for the group therapy sessions.

Delivery Method: MET-focused individual therapy

Session Phases and Times:

1. Review of progress (15 minutes)
2. Goal-setting (20 minutes)
3. Functional analysis (20 minutes)
4. Preparation for group (5 minutes)

Time: 1 hour total

Handouts:

- A personal goal worksheet
- Blank personal awareness worksheets for functional analysis (entitled Knowledge Is Power)
- A group preparation sheet titled Information and Expectations: Group Sessions

Procedural Steps

Begin by greeting the client. Notice if the client has brought back the folder of information. If so, state that you are glad to see that; if not, encourage the client to bring it next time.

Phase 1: Review of Progress. Begin the review of treatment progress by asking the client how he or she has been doing over the past week regarding the marijuana issue. The therapist should be prepared to listen for possible changes in the client’s behaviors, thoughts, and feelings regarding marijuana. Before asking a lot of questions, let the client tell you how he or she has been doing regarding his or her marijuana use or abstinence first. Respond with reflective comments, and attempt to elicit the client’s own motivation-enhancing statements. In order to get a fuller picture of the client’s marijuana-related behaviors, thoughts, and feelings, you may want to ask questions. Your questions may center on:
Behaviors related to marijuana:

• How much did you smoke over the past week, if at all?

• What was going on at the time you smoked (or felt like smoking)?

• Have you told any of your friends about your plans to stop smoking?

• Did you read the Guide to Quitting Marijuana brochure? What are your reactions to that?

Thoughts about marijuana:

• It sounds like you’ve given this issue a lot of thought. Tell me more about what you’re thinking regarding pot smoking at this point.

• What thoughts have you had about that PFR we went over last time?

Feelings about marijuana:

• How did you feel after you smoked?

• It sounds like you have mixed feelings about whether or not you want to quit. Tell me some more about that.

As you listen to the client, be prepared to express empathy, provide double-sided reflections as appropriate, reinforce client efficacy, and roll with resistance. After approximately 15 minutes of opening discussion, move into the goal-setting phase of the session.

Phase 2: Goal-Setting. Up to this point, you may have been hearing the client make statements indicating some motivation for change. If so, summarize this; if not, try to accurately reflect the client’s feeling that he or she is not yet ready to commit to change.

Either way, explain to the client that having a written goal increases the likelihood that the rest of the therapy will be meaningful and/or useful to him or her, and that he or she will be more likely to succeed. When working with clients who say they are not willing to give up marijuana, let them know that other goals may be useful to them. For example, some may decide to start by trying to reduce their marijuana smoking. Others may simply like to set the goal of learning more about the skills for quitting or reducing marijuana use.

Give the client a copy of the personal goal worksheet and a pen so that he or she can fill it out in the session. It is a good idea to have clients verbalize each section of the goal worksheet before writing it down. This way, the therapist can offer feedback and suggest modifications before ink
is put to paper, in such a way that the client is less likely to feel criticized. If the goal is vague, insufficient, or inappropriate, engage the client in a collaborative process to revise it. Offer to help clients with ideas if they get stuck. Many clients may be able to come up with some good ideas for steps they can take to achieve their goal. If they have trouble with this, here are some ways to help them:

- Tell them that many people find they can be more successful at stopping/reducing use by staying away from substance-abuse opportunities, and encourage them to write down ways they could reduce such situations in their lives.

- Ask them about ways that they could distract themselves by doing something else instead.

- Let them know that they will be learning more about specific strategies for addressing marijuana-related problems in the next three sessions.

When the personal goal worksheet is complete, be sure to have the client sign and date it. Ask the client to read it to you, even though you may have already heard all the parts of the goal worksheet in progress. You can explain to the client that reading it aloud helps reinforce the client’s motivation to achieve the goal. Ask permission to make a photocopy of the worksheet at the end of the session. Return the original to the client, and place the copy in the chart.
Personal Goal Worksheet

This is my goal regarding my marijuana use:

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Here are some important reasons for my goal:

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The steps I plan to take to achieve my goal are:

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Name __________________________  Date ________________
Phase 3: Functional Analysis. After having participated in the previous portions of the therapy aimed at improving motivation and beginning to resolve ambivalence, clients should now be ready to examine the function of marijuana in their lives. Actually, the groundwork for this has been laid. This exercise is included at this point to help clients understand that marijuana use doesn’t just happen but is rather a function of antecedents and consequences. The aim is to increase clients’ awareness of those factors, to provide better focus for the ensuing CBT interventions, and to enable better decision making on a daily basis.

To convey the concept of functional analysis, the therapist may begin with a social learning explanation of marijuana abuse. As the therapist goes through this explanation, he or she may draw on what the client has already described to illustrate the various points. The therapist should try to explain the concept in simple language, using concepts that the client can understand. Here is an example of such an explanation:

I want to explain to you how we think about marijuana problems. When someone has a marijuana problem, we think of it as a negative habit, similar to other habits like biting your nails or eating junk food. We try to help the person figure out what has been keeping the habit going. This way, if someone wants to stop the habit and knows what is keeping it going, he or she can use this information to help stop it. Does thinking of it as a habit make sense to you? [Discuss]

After a while, if someone has often gotten high in certain situations, just being in those situations can make that person feel like getting high. We call that a trigger. It could be anything about the situation like the time of day, whom you’re with, or even something like a type of music. You have mentioned some things that sound like triggers for you. What do you think some of your triggers are? [Discuss]

Another type of trigger can be how someone is feeling. Some people say that they feel more like smoking marijuana when they are feeling badly—like feeling bored, nervous, or angry. They say that smoking is a way of trying to cope with the bad feelings. Some people especially feel like smoking marijuana when they are happy or excited. Does this part of it—someone using to affect how they feel—make sense to you? [Discuss]

Sometimes people develop certain thoughts or ideas about their use, like ‘My friends will think I’m boring if I don’t take a few hits,’ or ‘I’ll just smoke this one time,’ or other ideas. These thoughts and ideas affect whether or not somebody uses.

The point is that marijuana use doesn’t just suddenly happen. Usually there are things going on around a person or in the way someone is thinking or feeling that affect whether or not he or she smokes marijuana. Knowing what affects your own use gives you more power to decide whether or not to use. And looking at both the pros and cons of what happens after you use also helps you understand
why you use and helps you make decisions about what you want to
do in the future. That is why we call this sheet Knowledge Is Power.
[Give them a blank copy of it; keep one for yourself.] Figuring out
the factors that lead to your own marijuana use gives you more
power to decide what to do next, and to break the habit, if you want
to. That’s the main thing that we are trying to do in this program—to
give you a lot of different ways to take back control instead of being
under the control of the habit.

Having given a rationale for treatment, the therapist should involve
the client in a functional analysis of his or her own use. The discussion can
focus on a recent episode(s) of use that the client has reported, or it could
focus on the client’s use in general. The therapist should fill in some of the
client’s responses on the personal awareness form while the client follows
along with a blank copy of his or her own. Here are some ideas for
discussing the subsections (from row one) of the worksheet:

Trigger:

What sorts of things are often going on when you decide to smoke
marijuana?

This may include places, people, activities, specific times or
days, and other situational aspects of use.

Thoughts and Feelings:

Can you remember your thoughts and feelings the last time you used?

Adolescents may be less likely than some adults to be able to
identify and label their feelings. It may help for the therapist to
offer some examples of how some adolescents say they have felt
before they decided to use (e.g., bored, angry, excited, sad). Also,
some adolescents may have trouble identifying their thoughts. The
therapist may be able to elicit their thoughts better by asking
clients what they were saying to themselves at the time.

Behavior:

Write down what happened at a recent time that these triggers were
experienced.

Often, in the example reviewed in the session, the client will have
smoked marijuana (possibly along with other substance use, which
should also be recorded). However, let the client know that this
analysis can also apply to situations in which the client chose not
to use.
Positive Results:

Some clients, when asked what good things resulted from use, may try to please the therapist by saying nothing; however this may not provide the full picture of a client’s use. The therapist may elicit a fuller response by saying something along these lines:

There have probably been some things that you have liked about using, or you wouldn’t have kept doing it.

Negative Results:

Ask the client what negative results followed his or her marijuana use. If the client has trouble coming up with some of these answers, the therapist may prompt him or her by asking about some of the areas covered on the PFR problem list, as well as other problems the client has mentioned thus far. For example, the therapist may ask the client whether the use had any effect on family relationships.

Show the client how you have recorded his or her responses on the personal awareness form, and ask for his or her reactions and questions. The therapist should make a photocopy of this example for the client’s chart. The original and an additional blank form both are given to the client, who is asked to use them to record other episodes of use or craving that occur before the next session and to bring these forms to the next session.
# Knowledge Is Power

## Personal Awareness: What Happens Before and After I Use Marijuana?

<table>
<thead>
<tr>
<th>TRIGGER</th>
<th>THOUGHTS AND FEELINGS</th>
<th>BEHAVIOR</th>
<th>POSITIVE RESULTS</th>
<th>NEGATIVE RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(What sets me up to be more likely to use marijuana?)</td>
<td>(What was I thinking? What was I feeling? What did I tell myself?)</td>
<td>(What did I do then?)</td>
<td>(What good things happened?)</td>
<td>(What bad things happened?)</td>
</tr>
</tbody>
</table>

Adapted from Jaffe et al., 1988
Sample Knowledge Is Power Form

Here is an example of how the self-monitoring record may look after the therapist has helped the client complete it while reviewing a recent episode of use:

**Personal Awareness: What Happens Before and After I Use Marijuana?**

<table>
<thead>
<tr>
<th>TRIGGER</th>
<th>THOUGHTS AND FEELINGS</th>
<th>BEHAVIOR</th>
<th>POSITIVE RESULTS</th>
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<td>(What sets me up to be more likely to use marijuana?)</td>
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<td>(What did I do then?)</td>
<td>(What good things happened?)</td>
<td>(What bad things happened?)</td>
</tr>
<tr>
<td>Friend called and invited me to smoke with him. Nothing else to do.</td>
<td>“I want to reward myself.” “I’m bored.” “Felt good about going 15 days w/o smoking, so felt OK about smoking today.”</td>
<td>Went out with friend and smoked.</td>
<td>Had fun. Felt good to get high, having gone 15 days without.</td>
<td>Broke the 15-day abstinence (although wasn’t too worried about this). Didn’t get as much done. Didn’t feel as healthy.</td>
</tr>
</tbody>
</table>
Phase 4: Preparation for Group. Remind the client that, as explained when he or she enrolled in the program, the next three sessions are done in a group. The group meetings will be 75 minutes long. Provide an idea of how many other clients will be in the group, how many males, how many females, and where it will take place. Describe the general format for each group session:

- Review of marijuana-related problems that occurred in the past week
- Discussion of new coping skills and how they relate to client’s problems
- Practice of new coping skills in the group
- Development of plans to practice the new coping skills at home.

Next, review the “Information and Expectations: Group Sessions” sheet with the client. After discussing it, the client and therapist should sign it. Ask the client what else he or she would like to know about the group, and also how he or she feels about the upcoming group sessions.

Clients may express some anxiety about the group sessions. If so, reassure them that this feeling of anxiety is normal and is likely to subside as they get involved in the group. Remind them that other clients may be feeling a similar nervousness. If a client is particularly nervous, help him or her think of ways to feel calmer (e.g., sitting next to the therapist, taking some deep breaths, telling themselves that it will be okay).

Tell clients that they are likely to find that the members of the group will be at different points regarding their motivation and readiness for change. If a client has expressed a good deal of motivation for change, talk about ways he or she may preserve that feeling when faced with others who may not be motivated for change. If the client feels negatively about change, ask how he or she feels about being in a group where some of the other clients may be more actively working on quitting. You may point out the benefit of staying open to a variety of perspectives. Also let the client know that while it will be acceptable to talk about his or her mixed feelings (including positive feelings about what the client feels marijuana does for him or her), he or she will need to be careful not to talk about it in a way that may trigger other members who are trying to quit. Let clients know that, regardless of each client’s readiness for change, all perspectives are to be treated with respect. Review the group rules for the upcoming sessions. Give the client an appointment card with the date and time for the upcoming group session written on it.

Remember to photocopy the personal goal worksheet and the personal-awareness sheet. Conclude the session.
Information and Expectations: Group Sessions

Group sessions will last 75 minutes. Please arrive on time and attend all group meetings.

If you cannot attend a group meeting, please call ______________ at ______________ ahead of time. If you miss a group session, you will be asked to make it up before or after the next session.

Your active participation is important to the whole group. All group members are asked to listen to one another without interrupting, to respect the opinions of others, and to offer feedback to other group members.

Each group member’s confidentiality is to be respected. What is said in group stays in group; please do not discuss what is said in group.

In order to make the group a safe place with a positive focus, the following behaviors are not allowed in group:

- Coming to group under the influence
- Threatening remarks or gestures
- Excessive profanity
- Wearing gang-related clothing
- Sexually inappropriate comments, gestures, or clothing
- “War stories,” bragging about drug and alcohol use
- Exclusive relationships

The above behaviors could result in a client being asked to leave the group.

I have read this information sheet, and I agree to comply with the expectations for positive participation in group.

__________________________________________  ____________________
client                                        date

__________________________________________  ____________________
therapist                                     date
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, whiteboard, 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, “drugalog$s” 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 3: CBT3—Marijuana Refusal Skills

Key Points:

• One's social circle gradually narrows as marijuana use increases. Clean friends are avoided and socialization with users increases. It is crucial that clients attempting to stop smoking marijuana develop refusal skills.

• It is best to avoid people who put users at high risk, but that is not always possible.

• Clients need to develop refusal skills to handle pressure effectively.

• When being pressured to use marijuana, immediate and effective action is needed.

• Practice will increase the likelihood that clients will use their marijuana refusal skills effectively when pressured.

Delivery Method: Cognitive behavioral group therapy

Session Phases and Times:

1. Introduction of group members to one another and a brief review of progress (20 minutes)

2. Review of real life practice (personal awareness forms) (10 minutes)

3. Marijuana refusal skills (45 minutes)

Time: 75 minutes total

Handouts:

• Marijuana refusal skills handout—enough copies for all clients and the leader

• Marijuana refusal skills reminders and real life practice handouts—enough copies for all clients and the leader

• Blank personal awareness forms (homework from session 2)

Materials:

• Prizes (for completion of real life practice exercises)

• Pens or pencils

• A session 3 poster
Procedural Steps

**Phase 1: Introduction to the Group and Brief Review of Progress.** The first part of the session is allotted to introducing group members to one another and to reviewing rules, which are posted in the group room. In order to help focus the group, each client is asked to share his or her goal for treatment. The therapist then asks an open-ended question about how the past week has gone regarding the marijuana issues. Because the resulting discussion could probably continue for the rest of the session, the therapist will have to rein it in to allow time for the material in this session to be covered. To facilitate this, the therapist may wish to open the topic with a statement like:

> Before we get into today’s topic, let’s take about 10 minutes to hear how things have been going for all of you this past week regarding the marijuana issue.

**Phase 2: Review of Real Life Practice.** Next, the therapist will ask clients who have completed and brought in their self-monitoring records to pick one episode that they wrote about and share it with the group. Group members and the therapist then share their reactions to what was written. Again, the time prohibits getting into detail or an extended discussion of people’s examples.

If none (or only one) of the group members have brought in written comments, give group members blank personal awareness worksheets (Knowledge Is Power) for functional analysis and have them verbally reconstruct one episode of craving or relapse that occurred during the past week. Allow time for feedback about those episodes. If at least two members have brought in written comments, just review their work. To the extent that members like the group attention, this may provide some incentive to complete the exercises. When people create answers on the spot rather than reading what they have written, they may become verbose; the time is better allotted to focusing on clients with written comments.

**Phase 3: Marijuana Refusal Skills.** Some of the following pointers and skills are included on the marijuana refusal skills poster, which provides visual reinforcement of the material to be covered. The therapist explains the following points regarding marijuana refusal skills:

1. **Being offered marijuana or being pressured to use by others is a very common high-risk situation** for marijuana users who have decided to stop using. Have you received such offers or pressures? In what situations?

2. As one’s use increases, there appears to be a “funneling” effect or narrowing of social relationships. The individual begins to eliminate nonusing friends and his or her peer group becomes populated with others who support and encourage continued use. Being with such individuals increases the risk of relapse.
3. Given the increased risk associated with social pressure, the best initial step is to avoid situations involving marijuana use. As this is not always possible or practical, marijuana refusal skills are necessary.

4. Being able to turn down marijuana requires more than a sincere decision to stop using. It requires specific assertiveness skills to act on that decision. Practice in refusing marijuana will help you respond more quickly and effectively when real situations arise.

5. The more rapidly the person is able to say “no” to such requests, the less likely he or she is to relapse. Why is this so?

Next, the group should review specific suggestions for the nonverbal and verbal behaviors recommended for marijuana refusal (also shown on the marijuana refusal skills poster). The marijuana refusal skills handout covers this material but adds more detail. Distribute this handout, and review each of the skills. Consider having clients take turns reading the points, in order to keep them all involved. Demonstrate, and then engage the group in demonstrating, the skills described. Group members often enjoy the part of the group in which they see the skills demonstrated effectively rather than ineffectively, and this is a good opportunity to increase their active involvement in discussion. Point out that these refusal skills are equally useful in turning down offers to use alcohol or other drugs. Following are the skills to be reviewed with the group. (A handout follows.)

Marijuana Refusal Skills

Nonverbal behaviors:

- Be firm. Speak in a clear and unhesitating voice. Otherwise you invite questions about whether you mean what you say. Demonstrate this skill by making the same refusal statement twice—once in a timid voice and once in a clear, firm voice. Have clients comment on the perceived effectiveness of each style.

- Make direct eye contact with the other person; it increases the effectiveness of your message. Again, demonstrate (or ask a group member to demonstrate) the same refusal with and without eye contact. Discuss your observations.

- Stand up for your rights! Don’t feel guilty. You won’t hurt anyone by not using marijuana, so don’t feel guilty. In many social situations, people will not even know whether you are using or not. You have a right not to use. Discuss your reactions.

Verbal behaviors:

- “No” should be the first word out of your mouth. When you hesitate to say “No,” people wonder whether you really mean it. Demonstrate the same statement both with and without the word “No” first. Ask for clients’ reactions.
• Besides saying “No,” suggest an alternative, something fun to do instead. Have the group suggest possibilities for alternative activities.

• If a person repeatedly pressures you, ask him or her not to offer you marijuana any more. Consider setting up a roleplay to illustrate doing this.

• After saying “No,” change the subject to something else to avoid getting drawn into a long discussion or debate about using. Have the group suggest possible changes of subject.

• Avoid the use of excuses like “I’m on medication for a cold right now,” and avoid vague answers like “Not tonight.” Discuss the rationale for avoiding excuses; they imply that at some later date you will accept an offer of marijuana.
Marijuana Refusal Skills

Nonverbal behaviors:

• Be firm. Speak in a clear and unhesitating voice. Otherwise, you invite questions about whether you mean what you say.

• Make direct eye contact with the other person. It increases the effectiveness of your message.

• Stand up for your rights! Don’t feel guilty. You won’t hurt anyone by not using marijuana, so don’t feel guilty. In many social situations, people will not even know whether you are using or not. You have a right not to use.

Verbal behaviors:

• “No” should be the first word out of your mouth. When you hesitate to say “No,” people wonder whether you really mean it.

• Besides saying “No,” suggest an alternative, something fun to do instead.

• If a person repeatedly pressures you, ask him or her not to offer you marijuana any more.

• After saying “No,” change the subject to something else to avoid getting drawn into a long discussion or debate about using.

• Avoid the use of excuses like “I’m on medication for a cold right now,” and avoid vague answers like “Not tonight.” These imply that at some later date you will accept an offer of marijuana.
The next part of the session involves practice, and clients are generally quite good at generating appropriate scenes to practice. Initially, the therapist will play the person who is being invited to use marijuana and will explain and demonstrate each of the following types of responses:

<table>
<thead>
<tr>
<th>Response Type</th>
<th>This Kind of Person:</th>
<th>Response Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive</td>
<td>Tends to give up his or her own desire in favor of another person's desire. Doesn't let others know what he or she is thinking or feeling.</td>
<td>“I didn’t want to smoke pot tonight, but if you want us to, we might as well smoke.”</td>
</tr>
<tr>
<td>Aggressive</td>
<td>Acts to protect his or her own rights but runs over others' rights in the process, which can cause others not to like him or her.</td>
<td>“I’m not smoking weed, and I don’t want anyone smoking around me! I’m throwing everyone’s weed away!”</td>
</tr>
<tr>
<td>Passive-Aggressive</td>
<td>Is indirect, hints at what he or she wants, possibly causing confusion and/or resentment in others.</td>
<td>“Are you all going to get stoned now? You know I’m in the treatment program . . . .”</td>
</tr>
<tr>
<td>Assertive</td>
<td>States his or her position and makes a direct request.</td>
<td>“I’ve quit smoking pot, and I’d like it if you would not ask me to smoke with you anymore. I still want to get together with you to do other things, like shooting some hoops, okay?”</td>
</tr>
</tbody>
</table>

First, the therapist describes each of the four types of responses listed above, demonstrating an example of each by asking one of the group members to play the person offering the marijuana. The therapist points out the ways that the first three types of responses may not be helpful to clients, highlighting the differences between these styles and the desirable assertive style.

Next, the therapist encourages group members to practice the assertive style of marijuana refusal in roleplays with one another. Group members are encouraged to offer one another support and constructive feedback as they practice these skills. Finally, clients are each given a copy of the marijuana refusal reminders sheet to take home. They are asked to fill in the real life practice exercise at the bottom of the sheet with either: (1) responses they actually make during the week to people who offer marijuana, alcohol, or other drugs; or (2) things they could say to turn down an offer to smoke marijuana. The therapist should attempt to get a verbal commitment from group members to complete this real life practice exercise.
Marijuana Refusal Skills Reminders

When someone asks you to use marijuana, keep the following in mind:

- Say “No” first.
- Make sure your voice is clear, firm, and unhesitating.
- Make direct eye contact.
- Suggest an alternative:
  - Something else to do.
  - Something to eat or drink.

- Change the subject.
- Avoid vague answers.
- Don’t feel guilty about refusing to use marijuana.
- If necessary, ask the person to stop offering you marijuana and not to do so again.

Real Life Practice

Listed below are some examples of people who might offer you marijuana in the future. Give some thought to how you will respond to them, and write your responses below each item.

Someone close to you who knows about your marijuana problem:

A school friend:

A coworker (if you have a job):

A new acquaintance:

A person at a party with others present:

A relative at a family gathering:
Session 4: CBT4—Enhancing the Social Support Network and Increasing Pleasant Activities

Key Points:

• Social support leads to improved confidence in one’s ability to cope and provides an additional source of help for quitting or reducing one’s marijuana use.

• Often individuals do not have as much support as they would like.

• There are several potential sources of support, including one’s family, friends, and acquaintances.

Delivery Method: Group cognitive-behavioral therapy

Session Phases and Times:
1. Review of progress (15 minutes)
2. Review of real life practice exercise (10 minutes)
3. Enhancing support (35 minutes)
4. Increasing pleasant activities (15 minutes)

Time: 75 minutes total

Handouts:
• A social supports reminder sheet for each group member
• A social circle worksheet for each member
• A social support practice exercise sheet (entitled Real Life Practice: Seeking and Giving Support) for each member

Materials:
• A drug test kit for each client
• Prizes (for completion of the real life practice exercise)
• Pens or pencils
• A blackboard, a “write and wipe” board, or a large poster board
• A session 4 poster

Procedural Steps

Phase 1: Review of Progress. Prior to formally beginning the group session, clients should be asked to provide urine samples for drug testing. The therapist waits outside the restroom when each client goes in to provide the sample. Clients should not be permitted to bring extra items into the restroom (e.g., coats, purses, etc.). If a multiple-capacity restroom is used, only one client should be allowed into the restroom at a time. When clients bring out their urine samples, the therapist should look at the temperature strip on the outside of the container to see whether the urine was voided recently (i.e., is within the expected temperature range). Clients should be informed that if they do not provide the requested urine sample, or if the sample is invalid, their sample will be considered positive for drugs,
meaning that drugs were present in their urine sample. If some clients say that they are unable to urinate prior to the group meeting, ask them to wait until after the meeting to do so. Occasionally a group client may say that he or she must use the restroom during the session and is unable to wait until afterward. In such a case, try to have a support staff person who is outside the group supervise the client providing the urine sample (as described above), rather than interrupting the group to supervise that client yourself.

After obtaining urine samples, begin the group meeting. Following initial greetings and updates (for example, telling the group that a client will not be in that day), the therapist should start with a general question about recent progress. For example:

As you’ve been working on the marijuana issue over the past week, has anyone had any problems or successes that you’d like to share with the group?

Allow sufficient time for discussion, attempt to facilitate members’ feedback and reactions, and offer your own comments, using MET and CBT strategies where possible. Move into the practice exercise review part of the session when the discussion winds down or in 15 minutes, whichever comes first.

**Phase 2: Review of Real Life Practice.** As in last week’s group session, keep the focus primarily on those who have done the real life practice exercise, unless fewer than two clients have done so. Have members read their responses to the refusal skills real life practice exercise, with the rest of the group offering feedback. Ask if any group members have had an opportunity to try out their refusal skills in a real life situation. If so, ask them to tell about their experience and reinforce their efforts.

**Phase 3: Enhancing the Social Support Network and Increasing Pleasant Activities.** This phase of the session starts with the therapist reviewing the rationale for increasing support:

- Social support leads to improved confidence in one’s ability to cope and provides an additional resource.
- Individuals do not often have as much support as they would like.
- There are several potential sources of social support, including one’s family, friends, and acquaintances.

Next, focus on teaching social support skills. Distribute the enhancing social supports reminder sheets (adapted from Monti et al., 1989) to the group. These skill guidelines are summarized on the poster for this session. Review the guidelines with the group and have them come up with examples from their own lives that correspond to some of the items. Here are the areas covered on the reminder sheet, with suggestions for covering them:
Enhancing Social Supports

Who might be able to support you? (Tell the group that “this refers to people who could help you with the goal you set regarding your marijuana use, as well as with other concerns in your life.”)

**Consider people who usually have been supportive in the past or those with no bias toward you.** (Encourage group members to give examples from their own lives.)

**Consider people who usually have been neutral in the past** (who aren’t coming in with a bias against you). (Encourage group members to give examples from their own lives.)

**Consider people who usually have not been supportive in the past but who might become supportive when they see your effort.** (Encourage group members to give examples from their own lives.)

**Consider friends, family, acquaintances, or others in your community.** (Prompt the group regarding categories that have not already been covered and may apply to group members, for example, teachers, clergy, coaches, extended family, guidance counselors.)

What types of support will be most helpful? (Again, have the group think of examples from their own lives of when they have needed, or when they may need, each of these types of support in the future.)

**Help with problem solving**—someone good at thinking of options

**Moral support**—someone to offer encouragement and understanding

**Sharing the load**—help with getting things done

**Information**—about activities, transportation, getting a job, etc.

**Emergency help**—for small loans, needed items, a ride, etc.

How can you get the support or help you need?

**Ask for what you need.** Be direct and specific.

The therapist should model the following ways of seeking support for the group. You may prefer to substitute a situation described by a group member during the meeting for the example below.
**Problem:** The client wants a friend to show support by doing things together other than just smoking marijuana.

<table>
<thead>
<tr>
<th>Type of Request for Help</th>
<th>Response Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect</td>
<td>The only thing you ever want to do with me is smoke pot.</td>
</tr>
<tr>
<td>Direct, but not specific</td>
<td>I’d like to spend time with you doing stuff other than smoking pot.</td>
</tr>
<tr>
<td>Direct and specific</td>
<td>I’d like to spend time with you, but I don’t want to smoke pot any more. Why don’t we go bowling this Saturday night?</td>
</tr>
</tbody>
</table>

Ask for group members’ reactions to the situations as they are modeled.

**Add new supporters.** As you work on something new, like trying to quit marijuana, you may need new or additional supporters. Ask group members who else’s support they could seek.

**Lend your support to others.** Talk with the group about how giving support allows you to get better at receiving support. Ask them for their reactions to this idea.

**Give your supporters feedback.** Let them know when something is or isn’t helping. Have the group think of an example of when someone may try to offer support that is not helpful, and how someone could tell them so.
Enhancing Social Supports Reminder Sheet

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

- Usually supportive, such as friends, family, acquaintances, or others in your community
- Usually neutral (aren’t coming in with a bias against you)
- Not supportive, but might become supportive when they see your effort

WHAT types of support will be most helpful?

- Help with problem solving—someone good at thinking of options
- Moral support—offers encouragement and understanding
- Sharing the load—help with getting things done
- Information—about activities, transportation, getting a job, etc.
- Emergency help—for small loans, needed items, a ride, etc.

HOW can you get the support or help you need?

Ask for what you need. Be direct and specific.

- Add new supporters. As you work on something new, like trying to quit marijuana, you may need new or additional supporters.
- Lend your support to others. It allows you to get better at receiving support.
- Give your supporters feedback. Let them know when something is or isn’t helping.

Adapted from Monti et al., 1989
In-Session Exercise: Social Circle Diagraming. Next, group members are asked to diagram their own social circles and to try to determine what support they may be able to obtain from their social circle. They are given pencils and asked to fill in this diagram during the next part of the group meeting.

After 5 to 10 minutes, each group member is asked to share what he or she learned or noticed about his or her own support system. Did group members notice possibilities for asking for and getting more support? They are not asked to share the specifics of their personal support system; there is not enough time for this. Although clients may want to explain every intricacy of their social circle (“Here we have my friend Casey; this is my sort-of friend Joe,” etc.), time will not allow this detail. It will be helpful for the therapist to explain this at the beginning of the discussion to decrease the likelihood that a client will feel cut off later. Please see the social circle diagram on the next page.
Social Circle Diagram

Use the grid below to diagram your own social support circle, focusing on those who could support you in addressing your marijuana issue.

Put your name in the center space, then fill in the names of those who do and/or could support you in your goal. Put the people who could be of greatest support to you closest to your space. Fill in as many of the spaces as you can.
**Phase 4: Increasing Pleasant Activities.** The following exercise is offered as a possible supplement to this session and should be included if there are at least 15 minutes available. Enjoyable activities can be a positive alternative to smoking marijuana. The group is asked to think of pleasant, fun, and safe activities that may serve as an alternative to smoking marijuana.

Tell them that some frequent marijuana smokers forget what it is like to do various things when they are not high and that some fun activities seem normal to them only when they are under the influence. Stopping or reducing marijuana use involves breaking the connection between these activities and being high. Many marijuana smokers may think that these activities will not be fun any more without marijuana, but they are often pleasantly surprised to find that the activities are as much fun, or even more fun, when they are not under the influence. Tell them that you’d like them to think of healthy, fun activities that they may be able to enjoy without, and instead of, marijuana use.

**In-Session Exercise.** While the group brainstorms possibilities, the therapist writes them down so that they are visible to the whole group. After several minutes, the therapist asks the group to consider if there might be a few activities on the list that they could add to their routine of activities. They are asked to write some of these on the bottom of their social circle diagram.

Next, they are asked to circle any of the listed things they would be willing to do over the next week. Each client is encouraged to tell the group one new thing he or she will do over the next week, including when, with whom, and how they will do it. Remind them that the idea is to do the chosen things without using marijuana, alcohol, or other nonprescribed drugs.

**Distribution of Practice Exercises.** Before the session concludes, practice exercise sheets (entitled Real Life Practice: Seeking and Giving Support) should be distributed and group members asked to complete them before the next session. Have the clients read the practice exercise sheets in the session so that they can ask any questions they may have at that time. Try to elicit some type of commitment from group members to complete both the written part of the exercise as well as the part where they actually ask for and offer support. This is in addition to trying out the pleasant activity.
Real Life Practice: Seeking and Giving Support

Think of a current problem that you would like help with.

Describe the problem: ____________________________________________
_________________________________________________________________

Who might help you with this problem? ______________________________
_________________________________________________________________

What might he or she do to give you the support you’d like?
_________________________________________________________________

How can you get this support from him or her? Remember, be direct and
specific: __________________________________________________________
_________________________________________________________________

Now, choose the right time and situation, and try to get this person to
support you. Describe what happened: ________________________________
_________________________________________________________________

Offer support to someone else.

Name a friend or family member who is currently having a problem and
who could use more support from you: ________________________________
_________________________________________________________________

Describe what you could do to lend him or her some support: _________
_________________________________________________________________

Now, choose an appropriate time and setting, and give support to this
person. Describe what happened: ____________________________________
_________________________________________________________________

Adapted from Monti et al., 1989
### Session 5: CBT5—Planning for Emergencies and Coping With Relapse

#### Key Points:
- Preparation for emergencies (unanticipated high-risk relapse situations) will increase the likelihood of effective coping.
- The group will brainstorm events that could precipitate a relapse.
- The problem-solving approach will be introduced as a way to cope with unforeseen events.
- A relapse is likely to be accompanied by guilt and shame, which exacerbates the problem.
- Use emergencies and lapses as learning opportunities.

#### Delivery Method: Cognitive-behavioral group therapy

#### Session Phases and Times:
1. Review of progress (15 minutes)
2. Review of real life practice (15 minutes)
3. Planning for emergencies and coping with relapse (35 minutes)
4. Termination (10 minutes)

Time: 75 minutes total

#### Handout:
- A personal emergency plan handout for each client

#### Materials:
- A blackboard, a “write and wipe” board, or a large poster board
- A session 5 poster

#### Procedural Steps

**Phase 1: Review of Progress.** Like previous group sessions, this session begins with a review of progress. Discussion about progress or problems over the past week is elicited by a general inquiry by the therapist. (See sessions 3 and 4 for further recommendations for conducting the review of progress.) During this phase of the group, the therapist offers to communicate the results of the clients’ urine tests for drugs (from samples obtained at the previous group meeting.) See “The Five Strategies of Motivational Enhancement Therapy” on page 21 for recommendations for discussing these results. The therapist should remind group members that this will be the final therapy session.

**Phase 2: Review of Real Life Practice.** Have group members read their responses to the seeking and giving support practice exercise. Ask the rest of the group to offer feedback. Reinforce attempts to try out the enhancing social support network skills through real life practice. If some
clients have not yet tried out these skills, encourage them to do so soon. Ask them to make a commitment to do this.

If the pleasant activities segment was done in session 4, ask clients about how they did on their plans to increase pleasant activities. Did they do the thing they planned? How did it go? Did they enjoy the activity or not? If they didn’t do it, what got in the way?

**Phase 3: Planning for Emergencies and Coping With Relapse.** Even if someone avoids situations involving marijuana use, knows how to refuse such offers, increases his or her support system, and plans positive alternative activities, he or she still may encounter unanticipated high-risk (emergency) situations and may relapse.

**In-Session Exercise: Group Brainstorming of a Potential Emergency Situation.** For individuals attempting to quit marijuana, an emergency situation consists of unanticipated circumstances that place them at increased risk for marijuana use. The group is asked to brainstorm the types of emergencies they may encounter. The therapist writes down the group’s responses in a place that is visible to all group members. After a period of unstructured brainstorming, provide cues to help the group think of types of emergencies they may have missed. Here are some examples of emergencies:

<table>
<thead>
<tr>
<th>Type of Emergency</th>
<th>Example of Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unanticipated trigger</td>
<td>Encountering substance abuse at a drug- and alcohol-free dance</td>
</tr>
<tr>
<td>Social separation</td>
<td>Friend moves away; breakup with boyfriend or girlfriend</td>
</tr>
<tr>
<td>School problem</td>
<td>Failing to be promoted; getting suspended</td>
</tr>
<tr>
<td>Adjustment to a new situation</td>
<td>Move to a new town; parents divorce</td>
</tr>
<tr>
<td>New responsibilities</td>
<td>New job; care for a sick family member</td>
</tr>
</tbody>
</table>

As seen above, emergency situations that can trigger a slip do not just include negative events but can also include positive events (e.g., a new job or a move to a better home). These situations entail the need to adjust to a number of changes in one’s environment and routine, when one’s coping skills may no longer fit the new circumstances. In emergency situations, individuals can increase their likelihood of success by using the problem-solving model described below, an approach developed by D’Zurilla and Goldfried (1971).

**Presentation of the Problem-Solving Model.** The following brief summary of the problem-solving model is derived from Treating Alcohol Dependence: A Coping Skills Training Guide (Monti et al., 1989), which asks:
1. “Is there a problem?” Recognize that a problem exists. We get clues from our bodies, our thoughts and feelings, our behavior, our reactions to other people, and the ways that other people react to us.

2. “What is the problem?” Identify the problem. Describe the problem as accurately as you can. Break it down into manageable parts.

3. “What can I do?” Consider various approaches to solving the problem. Brainstorm to think of as many solutions as you can. Consider acting to change the situation and/or changing the way you think about the situation.

4. “What will happen if...?” Select the most promising approach. Consider all the positive and negative aspects of each possible approach, and select the one most likely to solve the problem.

5. “How did it work?” Use the chosen approach. Assess its effectiveness. Having given the approach a fair trial, does it seem to be working out? If not, consider what you can do to beef up the plan, or give it up and try one of the other possible approaches.

**Group Practice Exercise: Problem Solving for Emergencies.** Have the group select one of the potential emergencies that were generated in the previous brainstorming exercise. Now ask the group to be sure that the problem is clearly identified, and have clients brainstorm various solutions. Write the possible solutions in a place that is visible to the whole group. Now have the group evaluate each of the possible solutions and pick one as the best choice. As this exercise is being done, describe how these brainstorming steps fit in with the problem-solving model.

**Group Discussion: Coping With Relapse.** Engage the group in discussion about coping with a relapse that may occur in response to an unanticipated high-risk situation. Here are some points to cover:

- **Relapse is not uncommon in recovery.** The important thing is how one deals with a relapse. Clients may think that after one relapse, the whole recovery plan is ruined, and they might as well give up. Let them know that this does not have to be the case.

- **Clients may learn something from a relapse.** Tell them that by looking at the circumstances of the relapse, they may learn situations to avoid, or changes to make in their coping skills.

- **Clients can choose to resume their efforts to live without marijuana after a relapse.** Ask the group for ideas about how someone could get back on track. Help the group cover the following suggestions:
1. Get rid of any leftover marijuana.
2. Ask for support.
3. Do other positive things instead of using.
4. Remind yourself of reasons for wanting to quit.

**Individual Practice Exercise: Developing a Personal Emergency Plan.**
By developing a plan ahead of time, clients will be less likely to be sidetracked by unanticipated emergency situations. Each client is given a blank personal emergency plan worksheet and asked to think about numerous solutions to each of the categories presented on it. Then he or she is to select the one or two he or she thinks may be the best generic plan. Of course, these plans will have to be somewhat general because of the unpredictable nature and circumstances of future emergency situations. Group members begin filling out these sheets in the group, to the extent that there is time available, and they are asked to complete this exercise at home.

**Phase 4: Termination.** The final 10 minutes of the group are set aside for a discussion of termination of therapy. Group members are asked what it has been like for them to participate in the group. They are given the opportunity to offer feedback to one another and/or to the therapist. Try to keep feedback to peers positive and supportive. Also, ask the clients their goals from this point regarding marijuana. After 10 minutes of termination discussion, the group concludes.
Personal Emergency Plan

Plan for: ___________________________

Name

Here are some possible emergencies that I want to be prepared for:

If one of these emergencies happens, this is how I will help myself cope:

--- DO the following:

--- Think things through.
--- Cool down by: ________________________________
--- Distract myself with:
  --- Physical activity. What kind? __________________
  --- Doing something relaxing. What? _______________
  --- Media (music, book, magazine, TV, movies).
    Which media? __________________________________
  --- Something creative (writing, art, dance). Which
    one(s)? _____________________________________
  --- Ask or call someone for help

Helpful People

<table>
<thead>
<tr>
<th>Who</th>
<th>Phone Number</th>
</tr>
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<tbody>
<tr>
<td></td>
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--- DON’T DO the following:

--- Smoke marijuana, drink alcohol, use drugs.
--- Act without thinking.
--- Get overemotional.
--- Isolate myself and/or stay away from people who care
  about me.
--- Stay in a high-risk situation.

If the emergency involves a relapse to marijuana use, the following steps will
help me stop using:

________________________________________________________________________
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.
Part IV: Session 6

• 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.
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.

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

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.
Part IV: Session 7

- 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
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?

   1 2 3 4 5

   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?
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.

<table>
<thead>
<tr>
<th>Rating (1–10) before practice exercise</th>
<th>Rating (1–10) after practice exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
Part IV: Session 8

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).

<table>
<thead>
<tr>
<th>Event</th>
<th>Thoughts</th>
<th>Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your mother is quiet when you get home.</td>
<td>“I must have done something wrong. She’s mad at me again, and we’re in for a fight.”</td>
<td>Apprehension, anxiety, fear, dread</td>
</tr>
</tbody>
</table>

- 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.

<table>
<thead>
<tr>
<th>Step #1</th>
<th>Chill out.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step #2</td>
<td>Collect your thoughts.</td>
</tr>
<tr>
<td>Step #3</td>
<td>Choose the best action.</td>
</tr>
<tr>
<td>Step #4</td>
<td>Change the way you think.</td>
</tr>
</tbody>
</table>

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.)

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

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 to 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/CBT 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).
Part IV: Session 9

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.

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Trigger</th>
<th>Description</th>
<th>Intensity (1–10)</th>
<th>How Long Urge Lasted</th>
<th>Coping Skills Used/Comments</th>
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### Intensity of Cravings

- **1**: Low
- **5**: Medium
- **10**: High
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):

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

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalizing: Thinking all situations and events are about you or revolve around you</td>
<td>“Everyone was looking at me and wondering why I was there. I know they must have been talking about me.”</td>
</tr>
<tr>
<td>Magnifying: Blowing negative events out of proportion</td>
<td>“This is the worst thing that could happen to me.”</td>
</tr>
<tr>
<td>Minimizing: Ignoring the positive factors of a situation or overlooking the negative factors of a situation</td>
<td>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.”</td>
</tr>
<tr>
<td>Either/or thinking: Seeing things in black and white, with no in-between</td>
<td>“Either I’m a loser or I’m a winner; either I’m bad or I’m good.”</td>
</tr>
<tr>
<td>Jumping to conclusions: Making a false connection between one set of circumstances and an outcome</td>
<td>“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.”</td>
</tr>
<tr>
<td>Overgeneralizing: Thinking that if something happens once, it will happen every time</td>
<td>“I am never going to be able to quit smoking pot. I always screw up.”</td>
</tr>
<tr>
<td>Self-blaming: Blaming yourself rather than identifying specific behaviors that you can change</td>
<td>“I’m no good.”</td>
</tr>
<tr>
<td>Mindreading: Assuming you know what other people are thinking</td>
<td>“My mom is mad at me because she thinks I am getting high again.”</td>
</tr>
<tr>
<td>Catastrophizing or “awfulizing”: Taking something small that happened and exaggerating it</td>
<td>“Since I’ve already relapsed twice, I’ll never be able to stay clean and sober.”</td>
</tr>
<tr>
<td>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</td>
<td>“I’ll never be able to pass this class. I may as well drop out.”</td>
</tr>
<tr>
<td>Putting oneself down: Thinking things that make you feel bad about yourself</td>
<td>“I don’t deserve things to get any better.” “I am no good, just as my father [or mother] said.”</td>
</tr>
</tbody>
</table>
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.
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


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


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

Cognitive-Behavioral Model of Anger


Relaxation Training


Anger Triggers Activity Sheets


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

Rationale, Reminder Sheet, and Real Life Practice Exercise


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

Active Listening


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


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


Learning New Coping Strategies


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

Rationale, Cognitive Thinking Errors, Reminder Sheet, and Real Life Practice Exercises
Part IV: Sources


Session Activity Sheet and Session Activity


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

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


Rationale

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.
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.


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?
Rationale

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

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.

**Destructive:** Aggressive, passive, passive-aggressive

**Constructive:** Assertive

Skill Guidelines

**Become more aware of situations that trigger anger:**
- Direct
- Indirect

**Become more aware of internal reactions to anger:**
- Feelings
- Sleep problems
- Physical reactions
- Fatigue or depression
- Mix of physical reactions and feelings
Session 8
Anger Management

Rationale

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

*Most people think that:* Events $\rightarrow$ Anger

*When really it is:* Events $\rightarrow$ Thoughts $\rightarrow$ Anger

Skill Guidelines


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!
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.
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.
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.