

**Treatment Manual for Supportive-Expressive  
Dynamic Psychotherapy :**  
Special Adaptation for Treatment of Cannabis (Marijuana)  
Dependence

Brin F.S. Grenyer, Lester Luborsky & Nadia Solowij

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# Treatment Manual for Supportive-Expressive Dynamic Psychotherapy :

## Special Adaptation for Treatment of Cannabis (Marijuana) Dependence

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## 1. Overview of Supportive-Expressive Dynamic Psychotherapy

Supportive-expressive psychotherapy was developed at the Menninger Foundation and Clinic, Menninger School of Psychiatry, Topeka, Kansas in the late 1940s and 1950s and originated in the papers on technique by Freud (Freud, 1910a; Freud, 1910b; Freud, 1912a; Freud, 1912b; Freud, 1912c; Freud, 1913a; Freud, 1913b; Freud, 1914; Freud, 1915; Freud, 1916-17; Freud, 1919; Freud, 1926; Freud, 1937). The treatment is systematically documented in a manual (Luborsky, 1984) that includes methods for evaluating adherence to the technique.

This present manual should be read in conjunction with the Freud papers on technique cited above and the general Luborsky (1984) SE manual. A number of special versions of the main SE manual exist which are tailored for specific disorders : opiate dependence (Luborsky, Woody, Hole & Velleco, 1995), depression (Luborsky et al., 1993), cocaine dependence and now this version for cannabis dependence. Although supportive-expressive dynamic psychotherapy has been established as an effective form of treatment for opioid dependence and depression, its effectiveness is as yet unevaluated for cannabis dependence. This manual was developed for the purpose of conducting a controlled study of SE psychotherapy of cannabis dependence. A controlled evaluation is presently being conducted at the National Drug and Alcohol Research Centre (1995-1996) and preliminary results suggests it is of significant benefit to this drug using population. However, final results and follow-up data are not yet in at the time of the publication of this manual.

The treatment can be either time-limited (with a set termination date) or unlimited. The term 'supportive-expressive' (SE) refers to the two main treatment techniques of this approach. Supportive techniques are ones developed by the therapist to create a positive, helpful and empathic relationship with the patient. Expressive techniques are those used by the therapist that are aimed at helping the patient to express and to understand and change problems. The focus is on identifying and interpreting each patient's recurring problematic interpersonal relationship themes as they occur (a) with the therapist (transference), (b) in relationships with other people, such as partners, family, friends and parents, and (c) around specific behaviours (eg drug taking) as attempts at finding solutions to the life problems.

The treatment has been repeatedly and successfully evaluated over the past thirty years. For example, the Penn Psychotherapy Project (Luborsky, Crits-Christoph, Mintz & Auerbach, 1988) evaluated the treatment on 73 mixed diagnosis patients and found a high mean Effect Size of 1.05. It has been used in the treatment of Chronic and Major Depression with even higher mean Effect Sizes of 1.80 and 2.75 respectively on

the Global Assessment Scale (Luborsky, et al, 1993; Luborsky et al., in press). It was a key treatment in the VA-Penn psychotherapy study of treatment for opioid-dependence (Woody et al., 1983), the largest and most successfully conducted study of its type. In this study, SE psychotherapy plus drug counselling was compared to cognitive-behavioural (CB) therapy plus drug counselling and drug counselling (DC) alone. At one month followup, pre vs post differences tended to be significant for the SE and CB groups and slightly less often for the DC group. The SE and CB groups reduced drug use more than the DC group. The SE patients made significantly greater improvements than the CB group on measures of psychiatric functioning and employment, whilst the CB group had greater improvements in legal status. These gains were maintained at 12-month (Woody, et al. 1987) followup for the SE group, with further improvement in psychiatric functioning, legal status and employment. The CB group also maintained gains with further improvements in drug use and psychiatric condition. Supportive-expressive psychotherapy is currently being compared to cognitive-behavioural therapy in a large scale NIDA-funded collaborative study of treatment of cocaine abuse.

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## 2. Diagnostic and Clinical Picture of Cannabis Dependence

### *Defining Dependence and Abuse (DSM-IV criteria)*

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) describes cannabis use disorders (Cannabis Dependence and Cannabis Abuse), distinct from cannabis-induced disorders (discussed below). No specific criteria are set by DSM-IV for cannabis dependence or abuse in addition to those already set for general substance dependence and abuse applicable across all substances.

Cannabis Dependence (304.30) is defined as a compulsion to use cannabis, generally without any physiological dependence. Nevertheless, tolerance to most of the effects of cannabis has been reported in chronic users. Reports of withdrawal symptoms do exist, but these have not been reliably shown to be clinically significant. DSM-IV states that "individuals with cannabis dependence may use very potent cannabis throughout the day over a period of months or years, and they may spend several hours a day acquiring and using the substance" (p. 216). It goes on to say that these activities may interfere with family, school, work or recreational activities and that individuals may persist in their use despite knowledge of the possible physical problems (eg. chronic cough) or psychological problems (eg. excessive sedation).

Cannabis Abuse (305.20) is defined by periodic use and intoxication interfering with performance at work or school, possibly being physically hazardous, for example when driving a car, and leading to possible legal problems as a result of arrests for possession. The use of cannabis may lead to family problems, such as arguments over the possession of cannabis in the home or use in the presence of children, etc. According to DSM-IV, "when there are significant levels of tolerance, or when psychological or physical problems are associated with cannabis in the context of compulsive use, a diagnosis of Cannabis Dependence, rather than Cannabis Abuse, should be considered (p. 217)".

A thorough review of the literature (Hall, Solowij & Lemon, 1994) suggested that a DSM-IV - like cannabis dependence syndrome probably occurs in heavy, chronic users of cannabis. There is good experimental evidence that chronic heavy cannabis users can develop tolerance to its subjective and cardiovascular effects, and there is suggestive evidence that some users may experience a withdrawal syndrome on the abrupt cessation of cannabis use. There is clinical and epidemiological evidence that some heavy cannabis users experience problems in controlling their cannabis use, and continue to use the drug despite experiencing adverse personal consequences of use.

It is likely that cannabis dependence is the most common form of dependence on illicit

drugs. A survey in the United States from 1980-1985 found that about 4% of the adult population had Cannabis Dependence or Abuse at some time in their lives. Cannabis use disorders appear more often in males than females, and prevalence is most common in persons between the ages of 18 and 30 years. Mild forms of depression, anxiety or irritability are seen in about one-third of individuals who use cannabis daily or almost daily, and physical and mental lethargy and anhedonia are frequently reported. The distinction between recreational use of cannabis and Cannabis Dependence or Abuse can be difficult to make because social, behavioural or psychological problems may be difficult to attribute to the substance, especially in the context of use of other substances (cannabis is often used with other substances). Denial of heavy use is common and people appear to seek treatment for Cannabis Dependence or Abuse less often than for other types of substance-related disorders. There is, however, a clearly demonstrated community need and demand for specialist cannabis treatment programmes (Stephens, Roffman & Simpson, 1993).

### *Cannabis-Induced Disorders*

Cannabis intoxication occurs within minutes of smoking, but may take a few hours to develop following oral ingestion of cannabis. It typically begins with a "high" feeling followed by symptoms that include euphoria with inappropriate laughter and grandiosity, sedation, lethargy, impairment in short-term memory, difficulty carrying out complex mental processes, impaired judgement, distorted sensory perceptions, impaired motor performance, and the sensation that time is passing slowly. Occasionally anxiety, dysphoria or social withdrawal may occur. The effects usually last 3-4 hours, longer if cannabis is orally ingested. The strength of the effects experienced is dose-dependent, but also a function of the route of administration and many individual characteristics affecting the rate of absorption, tolerance and sensitivity to the effects.

High doses of cannabis produce effects similar to those of hallucinogens and in the extreme may include severe anxiety, paranoia and panic attacks. Paranoid ideation may range from suspiciousness to frank delusions and hallucinations, and episodes of depersonalization and derealization have been reported. Because THC and other cannabinoids are fat-soluble, some of the effects of cannabis may occasionally persist or recur for 12-24 hours due to slow release of psychoactive substances from fatty stores into the bloodstream.

The criteria for a DSM-IV diagnosis of Cannabis Intoxication (292.89) are as follows:

- a. recent use of cannabis;
- b. clinically significant maladaptive behavioural or psychological changes that developed during or shortly after cannabis use (eg. impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgement, social withdrawal);
- c. two or more of the following signs developing within 2 hours of cannabis use: conjunctival injection, increased appetite, dry mouth, tachycardia;



d. the symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

A specifier of With Perceptual Disturbances may be applied to this diagnosis if hallucinations with intact reality testing or auditory, visual or tactile illusions occur in the absence of a delirium.

Other DSM-IV diagnoses include Cannabis Intoxication Delirium (292.81), Cannabis Induced Psychotic Disorder (With Delusions 292.11 or With Hallucinations 292.12), and Cannabis Induced Anxiety Disorder (292.89), which are diagnosed when the symptoms are in excess of those usually associated with Cannabis Intoxication and severe enough to warrant independent clinical attention.

### *Health Consequences of Cannabis Use*

Despite considerable research over the years, the major health and psychological effects of chronic cannabis use, especially daily use over many years, remain uncertain. A review of the literature established the following probable and possible health effects (Hall et al., 1994) :

The major *probable* adverse effects are:

- respiratory diseases associated with smoking as the method of administration, (eg. chronic bronchitis); the occurrence of histopathological changes that are precursors to the development of malignancy;
- the development of a cannabis dependence syndrome, characterised by an inability to abstain from or to control cannabis use;
- subtle forms of cognitive impairment, most particularly of attention and memory, which persist while the user remains chronically intoxicated, and may or may not be reversible after prolonged abstinence from cannabis.

The major *possible* adverse effects (yet to be confirmed by controlled research) are:

- an increased risk of developing cancers of the aerodigestive tract, ie. oral cavity, pharynx, and oesophagus;
- an increased risk of leukemia among offspring exposed in utero;
- a decline in occupational performance marked by under achievement in adults in occupations requiring high level cognitive skills, and impaired educational attainment in adolescents;
- birth defects occurring among children of women who used cannabis during their pregnancies.

High risk groups for health complications include adolescents, women of child bearing age and persons with preexisting diseases. Adolescents may have their educational achievement limited by the cognitive impairments associated with cannabis use, particularly affecting those with a history of poor school performance. Further, those who initiate their use in their early teens are at a higher risk of progressing to heavy cannabis use and other illicit drug use, and to the development of dependence on cannabis. Pregnant women who continue to smoke cannabis are probably at increased risk of giving birth to low birth weight babies, and perhaps of shortening their period of gestation. Women of childbearing age who continue to smoke cannabis at the time of conception or while pregnant possibly increase the risk of their children being born with birth defects. Persons with a number of pre-existing diseases who smoke cannabis are probably at an increased risk of precipitating or exacerbating symptoms of their diseases. These include individuals with cardiovascular diseases such as coronary artery disease, cerebrovascular disease and hypertension, individuals with respiratory diseases such as asthma, bronchitis and emphysema, individuals with schizophrenia who are at increased risk of precipitating or of exacerbating schizophrenic symptoms, and individuals who are or have been dependent upon alcohol and other drugs, who are probably at an increased risk of developing dependence on cannabis.

### *The Need for Treatment*

The available evidence suggests that long term cannabis users are likely to have a spectrum of health and psycho-social problems which point to the clear need for a specialized treatment approach. While most of the health problems associated with cannabis would benefit from the complete cessation of use, it is not clear to what extent the subtle cognitive deficits resolve following cessation. The main psychosocial feature from the literature is the likelihood of developmental immaturity and interpersonal conflict. These psychosocial and health issues are discussed more fully in chapter 7. The treatment of choice suggested here is a psychotherapy which both manages depression by bolstering fragile self-esteem during the process of quitting, and yet also seeks to foster mastery over problematic and developmentally arrested interpersonal relationship patterns. Achieving lasting change for deeply entrenched problems such as these requires many months of careful treatment. As with the other addictive disorders, relapse to drug use as an attempt to avoid or resolve these problems is the primary complication of any planned treatment course.

### *Findings of previous treatment trials for cannabis dependence*

There is a dearth of treatment studies of cannabis dependence. Two studies describe the treatment of cannabis dependence within the disease model of addiction and propose a 12-step treatment approach (Miller, Gold & Pottash, 1989; Zweben & O'Connell, 1988). Another focuses on improving cognitive functioning in the areas of verbal ability, short-term memory, and gestalt analytic-synthetic reasoning, based on

the observation that cannabis users' cognition is impaired or "in a fog" and needs clearing (Tunving, Lundquist & Eriksson, 1987). These studies do not have outcome data. A recent study (Stephens, Roffman & Simpson, 1994) treated 212 cannabis users (mean age 31.9) who had been smoking on a near-daily basis for an average of 11.83 years. Subjects were randomly assigned to treatment groups of 12-15 members. Half the groups were based on cognitive-behavioural relapse-prevention principles, and the other half were designed to foster social support among group members in their efforts to quit. Both groups at 12-month follow-up had achieved significant reductions in days of cannabis use per month (Effect sizes = 2.63 and 2.08 respectively) with no significant differences in effectiveness between groups. There are to date no published studies with outcome data for individual rather than group therapy of cannabis dependence, nor are there any reports of treatment based on psychodynamic theory. For these reasons, and based on the solid success of supportive-expressive treatment in other drug using populations, we considered it appropriate to use in the treatment of cannabis dependence. We report a published case study of SE psychotherapy in Chapter 9 (Solowij, Grenyer, Chesher & Lewis, 1995).

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### 3. Goals of treatment

The relationship between the patient and therapist is a special one, and goals define and prescribe this relationship and make it focussed on the tasks of therapeutic change. One goal is usually to cease cannabis use. Particularly in therapy with time-limits, goals (if they are reasonably achievable) modulate the breadth of material that can be dealt with in the time available during the sessions. The goals should be elicited with a statement such as "what are the three main goals that you want to achieve in these sessions?". There are three general goals for SE dynamic psychotherapy, which also represent the primary components of treatment.

#### 1) Supportive Component

To provide support to the patient's efforts by fostering the therapeutic alliance based on trust. Inherent within this support is maintaining a therapeutic frame which provides a secure and consistent place for the work to proceed. Support is used to bolster a patient's self-esteem by empathizing with their efforts to change and the difficulties under which they are labouring. Support also entails the recognition that the therapist and patient are working together as a team. A clear shared agreement is reached though the process of setting goals, and this helps to strengthen the frame and alliance.

#### 2) Expressive Component

To use the therapeutic setting as a place where the patient feels safe enough to express what they are thinking and feeling. The telling of narratives, and the therapist's interpretations of these using the Core Conflictual Relationship Theme (CCRT) method, helps the patient to work through repetitive conflicts and relieve symptoms.

#### 3) Mastery Component

The combination of a strong supportive therapy framework and an atmosphere that encourages the expression of problems, leads to the mastery of the repetitive interpersonal and drug problems. Mastery includes the development of self-understanding and self-control in the context of interpersonal relationships (Grenyer, 1994). It is a product of working through and evolves over the course of successful therapy (Grenyer and Luborsky, in press). The focus is on developing mastery of the conflicts in the CCRT. This helps the patient to reconcile ambivalent feelings at termination and through internalization to maintain gains following the end of therapy.

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## 4. Theory of dynamic change

Psychoanalysis emphasizes the formative influence of developmental experiences on the development of personality and on the genesis of problems. Erickson's developmental stages (Erickson, 1953) inform us about the challenges and risks to development throughout the lifespan. An inability to satisfactorily cope with wishes and needs often arises because maladaptive ways of relating to people have formed out of problematic experiences and have become ingrained personality traits. These maladaptive traits, because they do not lead to satisfaction of the needs of the person, are accompanied by symptoms of distress such as anxiety and helplessness. The preoccupation of psychoanalytic treatment, however, is not just on discovering the past, even though this is important. Treatment focuses on the present relationship between the therapist and the patient and how the patient is currently trying to get needs met in their wider social context. Changes in present functioning may benefit from knowledge of past traumas, but this knowledge does not in itself produce change. Change is brought about by working through the current relationship problems and patterns.

A number of psychoanalytic authors have turned their attention to the problem of drug addiction. Rado (1933/1956) developed the idea that drug use, by artificially producing elation, was an attempt to overcome feelings of depression. The cycle established was that of depression, followed by drug use, followed by deeper depression, followed by more drug use and so on. Rado also saw this cycle as indicating a more primary problem in getting needs met. Whereas in mature functioning the person is able to satisfactorily negotiate a way of satisfying their wishes through relationships, in drug addiction there are more immature developmental dependency traits, which are more narcissistic. That is to say, the drug use is a self-administered way of attempting (narcissistically) to get needs met, which in mature relations are achieved by interpersonal union and affiliation (Adams, 1978).

Fenichel (1945) emphasizes how drug use is an attempt to get not only sexual satisfaction but also for 'security' and 'the maintenance of self-esteem' (p. 376). Fenichel discusses how the drug is used in an attempt to fulfill wishes and desires. In the absence of mature ways of meeting these needs, the addict regresses to more infantile 'passive-narcissistic' ways of achieving gratification. Part of this is the addict's intolerance of waiting, of pain and of frustration. Needs and desires that are not met with quick gratification are not easily tolerated, and drug use is an attempt to quell this discomfort. This pattern of behaviour is "rooted in an oral dependence on outer supplies, [which] is the essence of drug addiction" (p.377). The sequence of elation (from the drug) and depression (from the withdrawal of the drug's effects) leads to the observation of the manic-depressive quality of the drug dependent's functioning. In established dependence, the drug is used primarily to avoid the

depression and frustration rather than to achieve elation. In Fenichel's view, treatment is best achieved after withdrawal from the drug.

SE psychotherapy traces within the therapeutic session the links between symptoms of distress and the attendant relationship conflicts. Freud's (1926) general theory of symptom formation develops the idea that symptoms such as anxiety arise from the perception of danger, particularly of losing someone loved. The loss of a loved object leads to an accumulation of unsatisfied desires and may result in helplessness. Within this theory, drug use may be seen as an unsatisfactory attempt to relieve the helplessness, anxiety and depression resulting from problems in getting needs and wishes met. In treating drug dependence, focus increasingly turns to underlying feelings of depression and helplessness arising from maladaptive interpersonal ways of relating. Change is brought about through mastering (understanding and controlling) the relationship conflicts and problems with a focus on the role of drug use within these interpersonal patterns. The therapist establishes a firm, consistent and predictable therapeutic framework to strengthen the helping alliance between patient and therapist, and maintains this by focussing on the patient's goals and fostering understanding of relationship conflicts how they interact with conditions for drug addiction.

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## 5. Treatment techniques

### *Supportive Techniques*

In successful psychotherapy a supportive relationship develops naturally between the patient and therapist. This has variously been called the "helping alliance" (Luborsky, 1983), the "working alliance" (Bordin, 1979) and the "therapeutic alliance" (Frieswyk, 1986). Freud discusses how "the patient's happy trustfulness makes our earliest relationship with him a very pleasant one" (Freud, 1913b, p.126). As the relationship develops, there remains a positive part of the patient-therapist relationship that is well grounded in reality, and continues for the benefit and success of the therapeutic collaboration. The helping alliance is "admissible to consciousness and unobjectionable", and "persists and is the vehicle of success in psycho-analysis exactly as it is in other methods of treatment" (Freud, 1912a, p.105). Bordin agrees that the helping alliance is central to bringing about change in most forms of therapy : "I propose that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the* key, to the change process" (Bordin, 1979, p.252).

A supportive relationship plays a part in all therapeutic work. By support is meant the establishment of a helpful working relationship that is mutually focused on helping the patient to strengthen their competence and esteem and achieve their goals. The supportive component of treatment is the bedrock so that the expressive techniques, interpretation of the Core Conflictual Relationship Theme (CCRT - chapter 6) , can be borne. Patients vary in the amount of expressive techniques that they can tolerate. Very sick patients will need primarily supportive techniques which aim to bolster their fragile self-esteem and life functioning. Supportive techniques generally proceed outside the analysis of transference, whereas expressive techniques are within the analysis of transference.

Support can also mean strengthening the patient's grip on reality. Defenses that are maintaining the person may need to be strengthened. In this case, expressive techniques, which may be aimed at removing defenses and exploring deeper regressive patterns of relating, should not be used if the patient is fragile. Support requires sensitivity, patience and a genuine wish to help.

The helping alliance reflects the degree to which the patient experiences the relationship with the therapist as helpful in achieving therapeutic goals. Part of the alliance is the patient's feelings of confidence and optimism that therapy and the therapist are being helpful. There is now a considerable body of research which indicates that the quality of the helping alliance predicts therapy outcome (Orlinsky, Grawe & Parks, 1994). Research puts particular stress on therapist respect, accurate empathy, warmth and

genuineness as being necessary ingredients (Beutler, Machado & Neufeldt, 1994). In short, the therapist must convey hope and optimism about their work and show respect and a liking for the patient. Luborsky (1984) suggests that a 'we' bond is fostered and that it is helpful to refer to the experiences that the patient and therapist have been through together in therapy to underscore the mutual feeling of therapy as a shared collaboration.

### *Expressive techniques*

Expressive techniques are those that are focussed on understanding the patient and helping them to change. The four phases of the expressive task are outlined by Luborsky (1984) as follows.

#### 1) Listening

This is the ability to listen to everything the patient says, including the seeming inconsequential asides and observe the coughs, stutters and gestures. Listening requires an 'open receptiveness' that is like a 'cultivated naivete' and is not cluttered by thoughts or hypotheses. The primary skill with listening is to do a lot of it, and be sure of your thoughts and evidence before responding to the patient's material. Luborsky (1984) separates three phases of listening depending on the degree of understanding : open inquiring listening, listening to form hypotheses, and listening to check the accuracy of formed hypotheses. Listening too closely, as Schlesinger (1994) remarks, is also a hazard : "when one is listening closely, perhaps too closely, one tends to follow the patient down the garden path. As the patient becomes vague or lapses into ambiguity, one tends to be carried along by the rhythms of speech and the superficial intent to communicate and overlook that what is being said has long since stopped making sense. By listening quite concretely to material, yet keeping a bit distant from it, one may hear what the patient is saying and what he is avoiding... If we listen too closely, too identified with only one aspect of the patient, we risk colluding in the accomplishment of defense and resistance" (p. 34). By listening too closely there is a real danger of being swept along with the patient's core relationship problems in a way that the therapist becomes a participant in them by emotionally reacting to them (eg. with sympathy, with fear) rather than by objectively listening and understanding.

#### 2) Understanding

Understanding is the ability to begin to see patterns between the main symptoms and the central relationship themes. Understanding, like listening, requires time and patience and thoughts need to be carefully formulated in the mind before responding. Formulating the main relationship theme in time-limited psychotherapy should be



accomplished early in therapy, within the first few sessions. This is discussed below in the section on formulating the CCRT.

Attention should be given to shifts in the patient's state of mind in the session, or other markers or clues such as momentary forgetting. Shifts may be indexed by a sudden change in topic, a mood swing, a freezing over of the conversation, a pause turning into a silence. The material that the patient was discussing immediately prior to these shifts may give clues to the underlying relationship problem. Typically this may become expressed within the relationship with the therapist. It is relevant at this point to explore how the patient is feeling about the therapist or therapy (eg. helpless, that there is no progress etc). It might be relevant to point out the shift to the patient and see what they reflect on it. The theme may be that the patient's expectations towards getting their wishes or needs met are negative. This might then be related at another time to their expectations about other relationship problems.

In discussions of the relationship between patient and therapist, it is useful to separate two aspects of the relationship. First, the real concrete or *objective* factors. Second, the *subjective* impressions of the patient regarding this relationship. Through the skill of listening, the therapist is able to distinguish the two and reflect upon them and the meaning these have for the patient. For example, a patient might say "all you ever do is sit there like a piece of ice". It is useful for the therapist to first acknowledge the reality - that indeed they do sit still, but then reflect more on what the feeling of ice is like for the patient. It is the patient's interpretation of what the feeling is like that is important to explore. The hypotheses below are some among many that could form themselves in the therapist's mind as attempts to understand the statement by the patient. It may be that the therapist is not felt to be warm and encouraging, but experienced as harsh and critical, or an object ("a *piece* of ice") rather than as a person, or as transparent rather than solid or opaque, or not just cold but icy (ice hurts when it touches the skin) and so on. There may be others in the patient's life that are also seen in a similar way - for example the patient's mother may have been felt as 'cold and stubborn'. There is also the feeling that 'all you ever do is sit still', a feeling that may reveal a wish for the therapist to do something more active. This also needs to be explored with the patient. It may be that the patient wishes that the therapist would tell them what to do (as if the therapist is in possession of the keys to the patient's problems and is not handing them over), or that patient may want the therapist to be more active, to touch them, or walk with them, or stand up so that the patient can feel smaller in a sitting position (like they were an infant etc.). It is the meaning of the subjective experience of the patient which points to some of the key features of the transference pattern.

It may also be relevant to see the use of cannabis as an attempt to cope with the central relationship problems. Although the use of cannabis may be effective in the short term in relieving anxiety, it is a maladaptive and unhelpful way of dealing with these problems in the longer term. Seeing the problem not in terms of cannabis use, but in terms of formulating more adaptive and adequate ways of solving relationship difficulties is the key to change. The patient should be encouraged to think of and find

alternatives to drug use that will lead to progress. Such change formulations and attempts by the patient should be commented on by the therapist. Encouraging the exploration of alternatives to drug use is an important part of achieving change.

### 3) Responding

This is the act of communicating to the patient some of what you have understood from listening. It is important to pitch this at the level that the patient will understand : a simple plain statement is preferable to a longer more complex formulation. Experienced psychotherapists tend to say less than inexperienced psychotherapists, but what they say is more helpful and accurate ie. more reflecting the main CCRT patterns rather than 'wild' interpretations that miss the mark. The general rule is to wait until you have a good understanding and solid evidence in support of your hypothesis. If you are unsure, then waiting will furnish you with the required knowledge.

Knowledge can come through noticing repetitions of similar themes in different contexts, through noticing the relationship between one set of conditions and a corresponding set of predictable reactions, and building up an idea of these sequences over the course of many sessions. For example, a patient may feel enraged and complain that one of his friends always takes advantage of him by smoking more than his share of the cannabis. Later, the patient may be discussing how he is expected to visit his grandparents much more than his brothers and sisters. A session earlier he may have been talking about how the psychotherapy sessions are never long enough and he feels that he is not getting the help he deserves. In all three examples the same pattern emerges : his wish to be treated fairly, the conviction that others are short changing him, and his response of feeling enraged and cheated. The basic principles of the scientific method - observing causes and effects - should structure listening and inform the ways you respond after this listening.

Responses should deal with an aspect of the CCRT pattern and if possible relate this to the emergence of a chief symptom (eg. the use of the drug, feelings of anger, states of helplessness etc). The principle of working-through specifies that the pattern will remain active in many different contexts over time and therefore it is not enough to interpret it once. The theme should be repeatedly traced in different contexts, particularly in relation to the therapist, to foster a slow and sure working-through of its manifestations that leads to mastery.

It is widely acknowledged that the transference relationship with the therapist is the most difficult for both parties to experience and discuss. The therapist can benefit in these instances from supervision which can help to hold the anxiety about the relationship and foster understanding of its dynamics. It may be useful in supervision for some trial transference interpretations to be practiced. Often a useful way of reducing the heat of the transference is to dilute it by discussing the situational pattern

outside therapy along with the transference eg. 'You felt cheated by your friend when he smoked more than his share of your dope and it may be also that here in therapy you feel cheated at times', or an alternative form would be to mention the transference first : 'perhaps at times here in therapy you feel cheated just as you felt this when your friend smoked more than his share of your dope'.

#### 4) Listening again

Interpretations, or responses, are usually pitched as 'hypotheses' that might contribute to understanding (eg. "it seems that .." or "perhaps the reason is that .." "It occurs to me that maybe ..."). It is very important to monitor closely how these interpretations are received and felt by the patient. Does the patient agree with your statement ? Disagree ? Appear shocked ? Uncomfortable ? Add new material that improves understanding ? Lapse into silence ? Change the topic as if they didn't listen to what you said ? Express relief and seem to warm to you and therapy ? How the patient responds gives good feedback on how they are experiencing the relationship with you and at what level they are able to tolerate your responses. Good responses that are pitched at the right level of understanding and complexity and touch on the central relationship problems have been shown to lead immediately to (a) a fall in anxiety level and (b) greater patient experiencing (exploration of the self) (Silberschatz, 1986; Weiss, 1986). Good interpretations appear to further progress in therapy, poor interpretations retard the therapy. In addition, it appears from research that making too frequent transference interpretations in a session can actually damage therapy by making patients feel criticized and leading to them to withdraw (Piper, Azim, Joyce & McCallum, 1991). It appears that interpretations need to be used judiciously, and transference interpretations at times appear to increase (not decrease) the 'heat' of the transference relationship (Luborsky, Bachrach, Graff, Pulver & Christoph, 1979). Listening is your guideline to how therapy is progressing and how to proceed within it. The matching of messages test (see Luborsky, 1984) is a useful technique whereby the therapist writes down after the session the main message that the patient expressed, and then writes down the main therapist response in the session. Good sessions are those where the two main messages are congruent.

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## 6. Formulating the Core Conflictual Relationship Theme

The Core Conflictual Relationship Theme (CCRT) method (Luborsky and Crits-Christoph, 1990) is a summary description of the patient's core relationship problems. The CCRT is used as a guide in the expressive component of treatment : to help make interpretations (responses to patient material). Particularly in short term therapy, it is important to maintain a therapeutic focus, and this should be centered around the CCRT. Research has shown that outcomes are improved when good quality CCRT-focussed interpretations are judiciously used in therapy sessions (Crits-Christoph, Cooper & Luborsky, 1988).

The CCRT technique (Luborsky, 1977; Luborsky, 1990) involves the analysis of narratives told by the patient which detail relationship interactions with close relatives or friends, the therapist, or the self. Relationship narratives are often tagged by an introductory phrase such as "I remember when ..." or "Like, for example, when ...". They are identifiable because they have a clear beginning, middle and end. They often illustrate a problem, or emphasize an observation. It is within the narratives that we can find the 'transference template'; the regular characteristic conflictual personality style of the patient.

Aspects of the narratives told in psychotherapy can be divided into a tripartite structure.

1. The wishes of the speaker, which correspond in psychoanalytic theory to instinctual needs. The wish, for example, might be to obtain love and nurturing.
2. The response of others to the patient, for example with hostility or aggression.
3. The response of the self, for example, withdrawing and becoming depressed.

The three elements of the CCRT therefore code the dynamics of the relationship interaction, and document the basic attempt by the patient to get their needs or instinctual drives satisfied. They narrate the expression of a wish, how this was received and responded to by another person, and then how this response of the other in turn affected themselves.

The essential aspect, then, of the CCRT is to listen to the wishes expressed by the patient and the sequences of consequences that typically flow from these wishes or needs. The wish-consequence sequences contain the essential CCRT elements. A case study illustrating the CCRT as applied to a long term cannabis user is given in chapter 9.

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## 7. Special principles of technique and issues for cannabis users

Special techniques are those that are formulated for the individual patient, based on their specific thoughts about drug use and the preconditions of use. Some of the dynamic issues specific to cannabis use are discussed.

### *Dealing with withdrawal symptoms during drug cessation*

DSM-IV lists the following examples of symptoms of possible cannabis withdrawal: irritability, anxiety or other moodiness accompanied by physiological changes such as tremors, perspiration, nausea and sleep disturbances. These have been described in association with the use of very high doses, but their clinical significance is uncertain. For this reason, DSM-IV does not include the diagnosis of cannabis withdrawal. There appear to be large individual differences in whether or not any withdrawal symptoms are experienced by long term users upon cessation of use. The therapist will need to carefully monitor withdrawal symptoms and utilize primarily supportive techniques during this stage of the treatment process.

### *Dealing with cognitive deficits from long-term use*

Cannabis use does not result in any severe cognitive deficits, but long term use may produce more subtle impairments in the higher cognitive functions of memory, attention and organisation and integration of complex information. While subtle, these impairments may potentially affect functioning in everyday life, particularly in adolescents with marginal educational aptitude, and among adults in occupations that require high levels of cognitive capacity. The longer the period that cannabis has been used, the more pronounced are the cognitive impairments. There are large individual differences in susceptibility to cognitive impairment, the nature of which remains uncertain. Some long term heavy users may present with vague complaints of possible problems of memory or concentration; they may report not being "as sharp" as they used to be. Others may not be aware of any cognitive impairment. The therapist should be aware that the subtle cognitive impairments, particularly attentional dysfunction, are not always accessible to the user's conscious awareness. Difficulty in focussing attention and high levels of distractibility may affect the process of therapy and the working through that should occur between sessions. Presenting information in a clear fashion and repetition of material across sessions early in therapy may help to overcome some of the difficulty patients may experience in integrating the therapeutic process while they are still using. It is recommended that more in depth expressive techniques proceed only after the user has quit for at least one week.

### *Dealing with Psychosocial Maturity and Relationship Problems*

A number of indicators of adverse development, such as minor delinquency, poor educational achievement, nonconformity and poor adjustment, have been attributed to cannabis use. Many of these may actually precede drug use and increase the likelihood of using cannabis. However, there is also evidence that chronic heavy cannabis use can in turn adversely affect educational and occupational performance and many other facets of adolescent development. While the effects are modest, they may cascade throughout young adult life, affecting choice of occupation, level of income, choice of partner and quality of life of the user and his or her family, and thus ultimately affecting adult adjustment and interpersonal relationships. There is suggestive evidence that chronic cannabis use has adverse effects upon mental health, with a possible amotivational syndrome, and may lead to involvement in drug-related crime. The earlier the initiation into drug use, the greater the involvement with the drug and the more likely the progression to experimentation with other illicit drugs.

Cannabis use may adversely affect interpersonal relationships. One reason for this is that heavy use during adolescence may produce a developmental lag, entrenching adolescent styles of thinking and coping which would impair the ability to form adult interpersonal relationships (Baumrind & Moselle, 1985). Further, there is a strong correlation between drug use, precocious sexual activity, and early marriage, which in turn predicts a high rate of relationship failure (Newcombe & Bentler, 1988b). Studies have shown that a high degree of involvement with cannabis predicts an overall reduced probability of marriage or an increased probability of early marriage, an increased rate of cohabiting, an increased risk of divorce or terminated de facto relationships, and a higher rate of unplanned parenthood and pregnancy termination. One theory holds that heavy cannabis users "tend to bypass or circumvent the typical maturational sequence of school, work and marriage and become engaged in adult roles of jobs and family prematurely without the necessary growth and development to enhance success with these roles ... [developing] a pseudomaturity that ill prepares them for the real difficulties of adult life" (Newcombe & Bentler, 1988b, p.35-36).

Further, adolescent cannabis users report having less social support than non-users (but this does not necessarily extend to adulthood), and users in general are more likely to have a social network in which friends and partners are also cannabis users. It is important to note too, that many chronic cannabis users appear socially and occupationally functional on the surface. However, upon cessation of use, reports of increased anxiety in social situations, interpersonal problems and difficulty in controlling anger, suggest that cannabis may have been used in a self-medicating or adaptive manner (Haas & Hendin, 1987). Nevertheless, improved functioning is generally reported following cessation or reduction of cannabis use indicating a lack of prior awareness of difficulties related to their drug use (Roffman, Stephens, Simpson & Whitaker, 1988).

A study of 150 adult heavy cannabis users (Hendin, Haas, Singer, Ellner & Ulman,

1987) found that approximately two thirds of the sample were in a steady relationship but only half of these were described as satisfactory, while among those who were parents, only 41 percent were highly satisfied with their experience of parenthood and 38 percent were dissatisfied, and only one quarter of those who were single were satisfied with their status. Difficulties in relationships with parents were also apparent, as only one quarter of the sample reported feeling close to their mothers, and only 15 percent felt close to their fathers, while 29 percent and 40 percent respectively judged their relationships with their parents as having marked difficulties or as generally problematic.

It is difficult to gauge the clinical relevance of these figures without comparable figures from a normative sample, but the data are suggestive of high levels of interpersonal difficulties in cannabis using populations. The most frequently mentioned psychological problem area reported by the above sample concerned feelings about themselves as insecure, having a low self-image and being overly introverted. Depression was the next most frequently mentioned problem, followed by relationship problems. These were described variously as serious dissatisfaction with their current relationships, fears of intimacy and commitment, lack of meaningful relationships in one's life, etc. One third of the sample focussed on themselves as the cause of the difficulties they were experiencing but more than half attributed their problems to a variety of external circumstances, including their childhoods and family relationships, their jobs or financial states, or where and with whom they were currently living. Less than 5 percent saw drugs as the primary cause of their problems.

Cannabis users are often in a situation where most of their friends are also users. A cannabis user who is intent on ceasing use will sometimes have difficulty coping with the pressures to use from group members. The basic affiliative function of the group may be a powerful reason for using in the absence of more meaningful or mature interpersonal relations. The group may have a juvenile structure which becomes more regressed and immature as each member becomes stoned. The decision not to use can have broad implications for the social life of the user. The strength of the therapeutic alliance can be an important factor in helping the drug user to make the necessary changes to promote abstinence.

Research has pointed to the importance of fostering positive social support in assisting the drug dependent patient to quit (Azrin, 1982). It may be helpful to encourage the user to associate with a 'buddy' or other supportive person who can be used for encouragement in the efforts to quit and remain abstinent in addition to the therapist. This might take a variety of forms, such as a spouse or a family member or a close friend. This social support is important in that it is different and is independent of that which is gained through the psychotherapeutic relationship with the therapist.

### *Attachment to the use of the drug*

Attachment to cannabis can impede the formation of meaningful interpersonal bonds to others and to involvement in work. In this case the drug is acting as a stand-in compromised substitute for the development of deeper interpersonal relationships. Difficulties in interpersonal relations can trigger cravings to use, thus creating a vicious cycle. This is one of the reasons why personality change is more difficult to achieve in drug-using patients. The therapist needs to become a catalyst in the struggle to shift the bonds of the patient away from drug use to more mature relations.

### *Dealing with feelings of helplessness and hopelessness*

Cannabis-induced disorders are characterised by symptoms that resemble primary mental disorders. Acute adverse reactions may resemble Major Depressive Disorder or Bipolar Disorder, while chronic consumption of cannabis may lead to symptoms resembling Dysthymic Disorder. In general, 30% of chronic cannabis users report experiencing some form of depression. A cross-sectional study has found an inverse association between life satisfaction and heavy cannabis use, and a positive relationship between heavy use and consultations with a mental health professional or psychiatric hospitalization (Kandel & Logan, 1984). A longitudinal follow-up of the same cohort found relationships between adolescent cigarette smoking and adult symptoms of depression (Kandel, Davies, Karus & Yamaguchi, 1986). In another study, strong relationships were found between adolescent drug use and emotional distress, lack of purpose in life and psychoticism. Emotional distress in adolescence predicted emotional distress in young adulthood (Newcombe & Bentler, 1988a).

Ceasing cannabis will often bring to the fore feelings of helplessness or hopelessness. It is useful to associate the emergence of these to (a) feelings that cannabis will solve the symptoms, and (b) cannabis is being used as a way of coping with these underlying feelings. Dealing with the underlying feelings of depression and helplessness at getting needs met, can often be a centrally important part of the therapy.

### *Dependence on or addiction to the therapist*

While it is helpful in the general course of events for the patient to become attached to the therapist, in the case of the drug dependent patient the situation presents special difficulties. Dependency may be seen on a number of levels. Dependency may be developmentally immature in the way that an infant is dependent on its parents for sustenance and protection. The patient that ceases drug use may therefore come to expect that the therapist will take the place of the drug and keep them happy and free from psychic conflict. The management of the patient's expectations is crucial in this instance. Supportive techniques can help to maintain this dependency (and keep the patient engaged in treatment) while the expressive techniques can help to open up the



patient to experiencing and mastering the problems of forming mature relations (ie. challenging the basis of their immature dependency). The decision of importance here is the balance between supportive and expressive techniques appropriate to the patient. Generally speaking, the greater the pervasiveness of the drug addiction, the more that supportive techniques will be needed in the weeks before and following cessation.

Maintaining a focus on the goals of treatment and mentioning the time limited nature of treatment often can also help to curtail an excessive transference of dependency onto the therapist. Marking the progress towards achieving these goals can help to keep up the momentum of treatment and the focus on change.

Dependency may also express itself as passivity. In this case the passive patient may be encouraging the therapist to be active and 'helpful', and yet undermining this helpfulness through spitefulness and aggression. This aggression towards the therapist may be expressed in a number of ways - such as through continued drug use, or coming late to sessions (thus 'spoiling' therapy and the work of the therapist). These passive-aggressive cycles need to be carefully understood within the general understanding of the transference patterns.

#### *Dealing with aggression and the lack of tolerance of frustration*

The cannabis dependent patient may use the drug as a way of obtaining relief from unbearable feelings of frustration and anger. Upon abstinence, the user may experience bouts of anxiety and rage which may be directed towards the therapist or other significant others (in a way that such feelings were previously acted upon through use of the drug). The supportive components of treatment delivered within a firm therapeutic framework may help to contain these feelings. The expressive components can help to turn the impulse to act upon the frustration to one of thinking about and controlling this impulse. Sometimes, the expressive components of treatment may, because they work at the central relationship problem, inflame the cannabis users' conflicts and provoke aggression. Careful monitoring of the users ability to tolerate frustration is necessary in order to prevent opening up large fissures which may threaten the therapeutic relationship and lead to premature termination. The aim is to open the cracks gently and kindly, with a gradual letting off of steam and a slow and steady formation in the users mind of the conviction that these feelings of frustration and anger can be tolerated.

#### *Dealing with concurrent drug use*

The treatment of cannabis dependence may be complicated by the associated use of other licit and illicit substances such as alcohol, amphetamines, LSD, benzodiazapines or opiates. In addition, cessation of cannabis use may bring with it increases in alcohol

or other drug consumption. Concurrent use needs to be understood within the general framework that has been discussed, but polydrug abuse represents a more severe form of dependence (often co-occurring with personality disorders). If the polydrug use is only occasional, longer forms of treatment with more supportive components may be more appropriate in these cases. If the use of other illicit substances is substantial, this should be dealt with prior to the issue of cannabis dependence, and may necessitate referral to an appropriate agency.

## 8. Establishing and maintaining the therapeutic frame

The frame is an important part of Supportive-Expressive psychotherapy because the frame establishes some basic preconditions for the patient being able to trust the therapist and feel supported, and also for the patient to be able to benefit from the expressive techniques without feeling attacked or rejected. Luborsky (1984) discusses some aspects of the frame on pages 61 - 70 of his manual and elsewhere.

Explaining what the therapist and the patient do in the sessions is an important part of establishing and maintaining the framework for therapy and keeping patients engaged. Therapy is explained to the patient in a socialization interview and this information may need to be repeated from time to time in the therapy. The establishment of goals to work towards also helps to establish the framework by which therapy proceeds. At a most basic level, the frame is these agreements by the patient and therapist :

- (1) to work together on a set of goals
- (2) to attend therapy at a specified place
- (3) to sit opposite each other in the room (in psychoanalytic psychotherapy)
- (4) to attend on a specified day or days per week
- (5) to see each other for a specified length of time each session
- (6) to specify or not specify the number of sessions
- (7) to prescribe or waive a fee for therapy
- (8) to prescribe what happens when either person misses a session
- (9) to prescribe what happens at times of vacation

The therapeutic frame creates a firm boundary protecting and containing the therapy. As Bleger points out, when the frame is carefully maintained by the therapist it is 'invisible' (Bleger, 1966, p.512) The frame is important because some of the most frequent errors that therapists make in psychotherapy are ones that break or damage the frame and the most common challenges that patients make to therapy are attacks on the frame. These often include problems in paying for therapy or becoming unpunctual. The behaviour of the therapist within the session is also an important part of the frame : the three guiding principles are *abstinence* (refusing to act out with the patient or at the expense of the patient); *anonymity* (the therapist does not self-disclose, but keeps the focus entirely on the patient's concerns), and *neutrality* (the therapist shows restraint in reacting towards the patient according to their own personal biases, but rather tries to empathically understand the patient's reality and identity). Aspects of these three qualities are also discussed in various contexts below.

The frame must be responsibly managed by the therapist. Handing over aspects of the frame to the patient (eg. getting them to decide on the fee) is counter-therapeutic and

can be very anxiety-provoking for patients, who come to therapy trusting that their unbearable feelings will be safely contained. By maintaining a firm frame (the frame being like an organizing, reality driven ego), the patient will feel safe to be able to explore the deeper and possibly more unconscious parts of their personality and past. The frame becomes a 'holding' environment which the patient can experience as secure and benign, which facilitates growth and development (Winnicott, 1956). How the frame is experienced by the patient needs to be considered, for at times it may be seen more as a prison than a place of safety, and the meaning of this needs to be explored and understood. Aspects of the frame are evoked from the very first telephone call. Below is a discussion of some key situations and variables that relate to the frame of therapy. More comprehensive discussions of the frame, from which some of the following has been derived, can be found in useful contributions by a number of psychodynamic authors (Bleger, 1966; Cherry & Gold, 1989; Fletcher, 1989; Freud, 1912c; Freud, 1913b; Gray, 1994).

### *The initial telephone call*

It is important that therapy does not begin on the telephone. People will often want to ask a lot of questions on the telephone, and this is partly due to their own fears about facing their problems and the difficult task of therapy. It is preferable to have the receptionist state: "I realize that you have many concerns but it is best for you to discuss these openly with the therapist". If the invitation to have a meeting with the therapist is accepted then a time should be offered. It is preferable to offer one or two realistic times rather than vaguely state "when would you like to come in". People who find it difficult to come to a first appointment often do not continue with therapy after a few sessions. It is advisable not to mention fees unless specifically asked on the telephone, nor to state that the person will go on a waiting list after the initial meeting if this is the case. These matters are best left for the initial meeting where all aspects of the situation can be fully discussed and understood. The person's name, address and telephone number should be taken and a letter confirming the first appointment should be mailed. It is useful for the first sessions to be thought of as a trial to see if the patient will become engaged in therapy with that therapist, for not all users will find their therapist or this form of treatment helpful for them. The above recommendations help to maintain and strengthen the frame by keeping the focus of the helping experience contained within the face to face therapy session.

### *Subsequent telephone calls and letters*

The basic rule here is that communication outside of the session is not recommended. However, if telephone calls or letters become necessary, as they often do, they should be as brief and as matter-of-fact as possible. If therapy issues or questions are raised at this time, it is best to state to the patient that "I understand these issues are important to you, and I suggest we discuss them at our next meeting". The intention

here is to contain the work of therapy within the frame of the sessions, and not have any leakage. When a patient rings to tell about a distressing event, or wants to change a time, it is recommended that the patient is encouraged to talk about these at the next scheduled meeting. In this way the patient feels that their needs are understood but that also the therapist contains these needs until the next face to face meeting where the meanings can be fully explored. To do the reverse, and simulate therapy over the telephone is to give your patient the impression that you are available all the time to meet their needs and that you do not have confidence in the patient's ability to manage and cope between sessions. This may ultimately make them anxious and lose confidence about you and therapy, and such a break in the frame may lead them to terminate. It is to be stressed that patients need to know that their therapist is able to be firm, consistent, stable and reliable about their professional work. Sometimes the patient will attempt to get the therapist to act immediately by saying that their situation is desperate. If you believe that the situation is a psychiatric emergency, then it is best to get a psychiatric team to visit your patient. It is important to realize that you are not offering a crisis service between sessions.

### *The involvement of third parties in therapy*

A difficulty arises when the therapist is contacted by a third party. This might be the patient's general medical doctor, or their previous therapist, or the patient's parents or spouse. The frame of privacy and trust between therapist and patient is threatened by these circumstances. Lingering doubts in the patient's mind about what was said (eg 'they think I am mad') can damage the work of therapy and lead to premature termination. Breaches of confidentiality do occasionally occur, and effort needs to be carefully expended to repair these breaks in the frame.

### *The therapists' private frame*

The focus of therapy is on the patient's difficulties. It is not helpful for the therapist to share personal information about themselves or anecdotes about other patients or people. This is the primary principle of anonymity. These serve to take the focus away from the patient's experience, and can evoke jealousy ('I am being compared with others') and depressive feelings ('I am just another patient'). It also threatens the frame of confidentiality ('I wonder if my therapist also talks about me to others'). Personal information from the therapist threatens the frame because it changes the relationship from an objective meeting focussing on understanding and helping to one where the boundaries between professional relationships and personal relationships is blurred. This can be extremely frightening for patients, because they are in a unequal and vulnerable relationship in terms of revealing personal information, and they need the therapist to maintain a strong boundary. Patients will put very strong (conscious and unconscious) tests on therapists to evaluate how well they maintain these boundaries (Weiss & Sampson, 1986). The boundary should always be maintained, even within the last five minutes of the termination session.

### *The primary stance of the therapist*

The stance of the therapist is to be both empathetic towards their patients, yet also maintain an objectivity so that they can also stand outside of their immediate problems and try to help understand them. This encompasses the principles of abstinence and neutrality. Patients come to understand that the expectations that they had about their therapist as being an ideal parent, friend or saviour, are unrealistic. The realization of these limitations in their therapists can deeply depress patients, but this also opens them to understand that in reality all their needs will not be met by one person and that their wishes will not always be fulfilled. Alternatively, patients may destroy the image of the therapist in their mind as a helpful person and instead feel them as persecutory. The mastery of these feelings can lead to a greater sense of self-control and self-understanding and prepares the patient for the end of therapy and a mature reappraisal of the ways they can successfully gratify wishes and needs.

### *Pre-therapy socialization interview*

It is recommended that an independent therapist conduct the initial assessment and socialize the patient about therapy. The basis behind the socialization interview is given in Orne and Wender (1968) and is described in Luborsky (1984). A patient information sheet has been adapted from these guidelines (Appendix 1) which may be useful to hand to the patient at this time. This interview can also help to gather the kind of information relevant to assign the patient to their therapist of choice. It is recommended that therapy commence very soon after the assessment in order to facilitate successful engagement into treatment.

### *The first session*

The ideal situation is for the patient to commence speaking at the first meeting. If this is not possible, it is best to say something like "My name is \_\_, we have fifty minutes together, I understand you have volunteered to come here today, It would be helpful if you to tell me about your difficulties". The essential point is to invite the patient to speak, but not to prescribe the topic of conversation. At other times in therapy the therapist might say "just tell me what you are thinking now". This is consistent with the rule of free-association of classical psychoanalysis (Freud, 1913b). Do not, for example, say "tell me about your drug use". It is recommended that the topic be left entirely up to the patient. Mentioning the time is an important part of the frame that will help to contain the interview.

Apart from the importance of the patient's expressed problems, it is essential that adequate time be set aside for discussion of the arrangements : fees, times, arrangements for missed appointments, vacation, therapy time-limits (if any). This topic should be introduced as soon as possible, preferably before the interview has

proceeded more than 25 minutes. It may take considerable time to discuss these issues and because they are the foundation blocks of the frame they deserve time and care.

### *Pacing the session*

An important part of the framework is in pacing the session so that it proceeds smoothly and has a natural beginning, middle and end. The first ten minutes should be left empty for the patient to express their immediate concerns and recollections with very little therapist comment. The next 30 minutes then contains the work of therapy - the expressive components and the joint search for understanding. The final 10 minutes should be spent drawing back from the intensity of the material to again more general work. A frequent error of inexperienced therapists is that they interpret too soon and interpret for too long, such that the patient is suddenly cut off when the fifty minutes have arrived with little time for reflection or the building of the alliance. Another error of therapists is that they remain within the supportive mode for the whole session, so that little progress and exploration proceeds.

### *Keeping case notes*

As Freud recommends, therapists should not make any notes during the session, but rather should trust their memories (Freud, 1912c). An important part of professional treatment is to ensure that each session is written up as it occurred from the moment the patient arrived, to when they leave the treatment unit. This is best achieved on the day of the session. Try to remember the actual content of conversations and record these near verbatim without writing too much interpretive material. Keeping case notes can be a way of helping to think about the processes and working through the transference and counter-transference patterns as they occurred in the interaction. Keep the case notes active between sessions - often thoughts about the session and incidents will occur to you later (through a process of reminiscence) and these are also useful to append to the case notes with the date that they occurred to you. It can be valuable to re-read the notes before the session as long as the therapist still tries to listen freshly. A new week is a new experience, and patients are often quite different and discontinuous in presentation from the previous session.

### *Maintaining the frame during the sessions*

Therapists lease their time by the hour. Sessions should be exact in timing - 50 minutes is recommended, which leaves 10 minutes between patients for recuperation. The patient should be encouraged to find a regular weekly time. It is to be emphasized how a regular time each week strengthens the frame and creates an invisible expectable mental space for therapeutic work. Specified times should therefore be reserved well in advance. It is best to mail to the patient these arrangements in writing once they have

been agreed. Short term work is best carried out on a weekly basis. Fortnightly sessions are generally not recommended because the consistency and focus of the work is very difficult to maintain.

The physical arrangement of the therapy room should be set out in an identical fashion from session to session to create a mental consistency. This also avoids the depressive feelings in the patient that the room is not their special place if it has obviously been rearranged and used by other patients. Situations which stir up jealousies and competition between patients should be minimized. It also shows respect for the patient if the room is well prepared. Sensible precautions include the following. The therapy door should preferably not be able to be accidentally opened from the outside (or at least has clear warnings about privacy). An alternative exit or other arrangement should be in place so that patients can leave by another door, avoiding disturbing patients in the waiting room. Telephone calls and other disturbances should be prohibited. Patient files and other records should be securely stored away and out of sight. A fresh jug of water and glasses should be available, as should be tissues. Freud also recommends a blanket, and this is relevant for work using a couch but can be a useful item to have available in all settings.

Patients will sometimes want to challenge the ritual of the scheduled hour each week. They may complain that they needed the therapist earlier in the week, but today they do not need to come. The reality is that the therapist cannot operate services on the basis of demand. However, the frustration felt by the patient may be a clue to deeper maladaptive expectations about close relationships. By the therapist maintaining a firm frame, the focus can be shifted to address these needs that the patient is expressing. There are dangers in the therapist accommodating many changes in the time of the sessions. These represent challenges to the frame, and once again the basic principles of consistency and continuity need to be observed. The therapist who accommodates many changes may be seen by the patient to be very needy of the therapy to continue, and this will make the patient anxious and concerned that the therapist is not able to maintain firm professional limits around the frame. On the other hand, the patient may see the therapist as being rigid and uncaring if changes based on need are discouraged. The important point is to try to understand what needs the patient is expressing and how they are responding to the therapist's reactions to these needs in terms of the CCRT formulation. Thinking about and exploring the meaning of challenges to the frame with the patient, such as a request for a new time, is one of the most important tools of the therapist.

Crucial times for the analytic frame are beginnings and endings of the session. Careful attention should be given to the first impressions and exact first communications of the patient and the resistances at the end. Evaluate your feelings that are evoked when the patient leaves the room. Common feelings are guilt for 'abandoning' the patient. These feelings also give real clues as to how the patient's CCRT pattern is present in the relationship with you.

A particular difficulty may arise if the user comes to therapy intoxicated. If there are



reasonable grounds for making this conclusion then the session should be terminated because of the interference of the drug on the session. It is important to show that therapy is something to be valued and protected and that a firm boundary should be established around it. Having said that, it will of course be important to understand this act within the framework of the transference and words need to be carefully chosen in dealing with this situation. Re-establishing the frame in subsequent sessions will be an important task.

### *Missed sessions*

Missed sessions are a common occurrence in drug-using patients and should be tolerated and understood within the transference patterns unique to that patient. The meaning of missed sessions should be fully explored at the next session in terms of the patient's ongoing interpersonal problems. Compliance should be reinforced by reminding patients promptly if they have missed appointments, through a simple letter (or telephone call) telling them of the next meeting. This will help to re-establish the frame.

Dealing with payment for missed sessions is one of the most challenging situations with which the therapist has to deal. Once again it is important to listen to what the patient says and try to understand the meaning of their reactions both to being asked to pay for the missed session and their reasons for missing the session. It is recommended that all missed sessions be paid for because in reality therapists cannot fill missed hours, even if notice is given well in advance. These conditions should be firmly established and agreed to at the start of treatment. The patient may express rage at the therapist's 'meanness' and 'inflexibility' and this needs to be understood in terms of a real enactment of a CCRT pattern. In a case like this, the patient's wish (eg. to be indulged, to have special favours) is met by a negative response from the other (the therapist insisting on payment) which leads to the patient feeling enraged. The therapist might respond to such a situation by saying 'you feel it is unfair that I am asking to be paid even though we agreed to these arrangements at the start of therapy'.

### *Fees*

Money is an emotionally charged currency that will almost always find its way into the dynamic material of the therapeutic sessions in one way or another. The meaning of money and problems with paying for therapy can touch on the core relationship problems that the patient brings to therapy and are issues that need to be carefully interpreted. Failing to sensitively deal with the dynamic issues of fees can damage the therapeutic frame, possibly fatally, but with care and perseverance problems can be rectified.

The general recommendation is that fees be fixed at a reasonable level and only varied

or reviewed at a set time annually. The end of the financial year or calendar year is an ideal time. This avoids patients seeing rises in fees as being a personal attack. The fixing of fees sends a strong signal to the patient that the therapist is prepared to value what they offer. In time-limited therapy the fee should remain the same throughout the duration of the therapy.

Sometimes the treatment setting is one where there is no expected financial contribution to be directly borne by the patient. This can occur in government-run agencies and institutions where the therapist's wage is met by the taxpayer. The issues here are less difficult than one might assume because the institution and government tend to separate the transference-aspect of fee payment from the sphere of the therapist-patient relationship. Treatment studies investigating the issue of fee payment have generally found little difference in outcome between those patients that pay a fee that those that are not required to pay, although these studies are not well controlled and there are suggestions that paying a fee is a way of making the patient feel responsible for their decision to attend therapy. The situation is entirely different, however, when it is the therapist who personally decides to offer free treatment. Such a situation is dangerous because of the obvious transference and counter-transference issues. The patient may feel indulged by the therapist, an attitude which may irretrievably prevent treatment from having its desired effect. .

Freud observes some of the dynamic issues at stake in the setting of fees, and notes that "powerful sexual factors are involved in the value set upon it; he [sic] may expect, therefore, that money questions will be treated by cultured people in the same manner as sexual matters, with the same inconsistency, prudishness and hypocrisy" (Freud, 1913b). Freud recommends that money be discussed in the same matter-of-fact frankness that should be employed in discussing sexual matters. The intimacy of the setting and the private and confidential nature of the relationship can evoke comparisons between the therapeutic relationship and more ancient relationships such as between priests and confessors or prostitutes and clients. Strong sexual and spiritual aspects of the relationship are present in varying conscious and unconscious degrees and influence the way money is symbolised as either payment for indulgences, payment to atone sins and guilt, or payment made as an offering to a superior spiritual guide. These attitudes can influence the therapeutic relationship in profound ways. On the prostitute-patient model, the patient may see their payment as being to acquire an indulgent friend who will shower them with attention, indulgences and even love. On the priest-confessor model the patient may see their payment as being to obtain special knowledge, insights and enlightenment from the therapist. Both these models probably have parental precedents with a the young patient wishing their parent to be indulgent or authoritarian. The activation of these attitudes may pose dangerous threats to the integrity of the treatment frame and these need to be carefully assessed in the context of the material that is brought by the patient in respect to the discussion of fees. The essential principle is to understand the expression of wishes towards the therapist in terms of the CCRT formulation and for the therapist to remain neutral, abstinent and anonymous.

Fees should be fixed at the start of therapy and agreed to by both parties. The issue of fees should be introduced by the therapist with a clear statement of the price for the time. Often patients will discuss or complain of difficulties in meeting the fees. These discussions may include illustrations of financial hardship and extenuating circumstances that will make payment difficult. It is important to try to understand and identify the mature and realistic appraisal by the patient of their financial position from immature pleas and other emotional factors. Accurate information about the patient's financial position is important at this stage. Strong transference pulls can be used to influence the therapist's position and the therapist may be swayed away from a position of empathising to sympathizing with the patient's predicament. The therapist is on dangerous ground here and there may be a risk of colluding with a patient's unconscious needs, which might include to be mothered and dependent. Alternatively, suggestions by the patient to pay less may be interpreted by the therapist as a personal attack on their worth and professional integrity that can lead to underlying resentments. Rarely a patient may offer to pay more than is asked, and this needs to be carefully understood. Such a gesture may be an attempt, disguised as magnanimity, to make the therapist feel inferior. This attitude may stem from the patient's unbearable persecutory feelings of inferiority. The firm setting of a fee is usually the safest way of avoiding these attacks on the frame, but also the attacks, if they come, need to be fully analysed and understood.

It is important to appraise accurately who is paying for the therapy. The general rule here is that the patient should be bearing the direct burden of the cost of therapy. Difficulties can arise when, for example, a male patient in his early twenties has his therapy paid for by his mother, or a husband pays the bills for his wife's therapy. Once again these factors can be powerful ways of maintaining and repeating the core relationship problems of the patient, such as the need to be mothered. Payment by a person other than the patient introduces a third party into the therapy frame, and the implications of this for the therapeutic integrity of treatment need to be carefully interpreted and understood.

It is recommended that fees be collected at each session, at the beginning of the session. Collecting at each session avoids the problems inherent in trying to recoup larger sums after the services have been rendered, and also assists in immediately discussing and dealing with issues such as payment for missed sessions. Payment at the beginning of the session allows issues about payment to be directly dealt with during that paid session, rather than being hastily made after the session's hour has expired or being left till the next session when the issues may be lost, further distorted or resentments may have grown. It is important to be aware of strong transference pulls by the patient to extend the therapy beyond the set hour. Obtaining extra "free" minutes of the therapists time can gratify the patient who wants to be indulged and mothered or can be a way of unconsciously frustrating and punishing the therapist. Leaving payment until the end of the hour (unless one has a third party to collect the fees) leaves the ritual of collecting the fees open to manipulation. The patient may suddenly introduce various topics related to difficulties in payment which can take extra time to discuss.

Another example may be the patient's apparent (motivated) "forgetting" to have the cheque book at hand by leaving it in their motor vehicle. This device necessitates either the therapist agreeing to wait (thus obtaining free time or frustrating the therapist) or letting the patient pay at the next session (indulging the patient with a seemingly "free" hour). Difficulties such as these should be avoided.

The payment of money by the patient may present another difficulty. The patient can devalue the relationship with the therapist, the pain and suffering shared, and the difficult battles fought by reverting to a depressive accusation that the therapist "is only here because of the payment". The implication is that the therapist does not care for and about the patient, that the patient is not special, but the therapist is simply going through a ritual to earn a living. This can be exacerbated when the patient is required to pay for missed sessions - the depressive conclusion being that the therapist doesn't care whether they come or don't come to the sessions as long as payment is received. Statements of this flavour are attacks on the therapist and the therapy, and the immediate unthinking reaction of the therapist might be to defend themselves and proclaim that the patient is more important than money. These statements play upon any unresolved guilt feelings that the therapist might have about asking a suffering distressed person for money. These situations must be handled like other attacks on the frame, with great care, patience and understanding. Often the best strategy is to wait for further material, personally analyse any counter-transference feelings, and try to reflect on the meaning of the patient's attack in terms of the wish-consequence sequence.

### *Changing therapists and its impact on the patient*

An enormous threat to the frame comes at a point when circumstances dictate the necessity to change therapists mid-way through therapy. The frame has been set to provide consistent and continuous care through the therapeutic relationship. The sudden or inadvertent departure of a therapist can revive in the patient primitive feelings of abandonment. It is important in these instances for the patient to be given as much warning as possible about changes in therapist, and to give the patient the choice as to how to proceed, given the circumstances.

### *Termination*

In establishing the therapeutic frame in the first session, it is recommended that termination be discussed and how the patient and therapist will know that it is time to end therapy. The case is different in time-limited therapy, where a set number of sessions are agreed. Setting goals that are realistic and achievable is the best method of prescribing the work and giving it shape so that the ending can naturally appear when the goals are met. It is natural however, that towards the end of therapy there will be a temporary return of the original symptoms as the anxiety of separation

becomes a reality. There may also be a sense of disappointment that not all will be achieved as hoped. These symptoms and feelings should quickly abate and be mastered if the therapist helps the patient to understand them within the context of the ending.

It is useful to recommend at the commencement of therapy that when termination appears imminent that the patient and therapist set aside at least two or three sessions at the end to discuss terminating. This will avoid the patient suddenly announcing the end of therapy during a session and not leaving enough time for this to be fully understood.

Time-limited therapy is useful in that the length of therapy is set at the start, thus avoiding some of the problems with bringing therapy to an end, but also has the drawback in that important work may be left unfinished. On the other hand the therapy has a natural beginning, middle and end, and much of the same material that appears in longer therapies will appear in condensed form in time-limited treatment. Termination should be discussed often during therapy, and the ending of each therapy session is like a small termination which prepares the patient and therapist for the final separation. The length of therapy should be mentioned often (eg. "we have seven more sessions") so that the patient develops a perspective of the overall length of therapy. Discussing the meaning of endings in a more broad context also helps to locate the meaning of termination within other separations and endings in the patient's life. Working through the meaning of termination is perhaps one of the most important tasks of therapy and can help to ensure that termination is borne by the patient. Two parallel dangers in termination are (a) destroying the therapist in the patient's mind : a manic defense against the pain of ending by blocking out the ending, or (b) replacing the therapist with someone else : rushing into another dependent relationship in order to avoid the pain of termination. Both dangers may need to be canvassed at some point towards the end of therapy to help keep the momentum towards a mature separation.

The patient may wish to discuss the possibility of further sessions after termination. The therapist may wish to negotiate this after some specified period of time has elapsed after termination or may refer the patient to another therapist. In recommencing treatment, the same recommendations apply about establishing the framework with a new set of prescribed goals.



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## 9. Case study of SE psychotherapy for long term cannabis dependence

A 35 year old male with an 18 year history of daily cannabis use approached the treatment centre for assistance in ceasing his drug use. He had commenced using cannabis at the age of 17, progressing immediately to regular use of approximately 6 gm of cannabis per day (mostly potent "heads") on a near-to-daily basis up to the age of 28. He then went through a period of irregular use with an attempt at giving up but by the age of 30 had resumed heavy daily use. He described his unsuccessful attempt to stay off the drug as being due to a lack of resolve on his part, a lack of support from others, a lack of "knowing himself" and a variety of "social and life pressures". He claimed not to feel physically dependent on cannabis but defined a psychological dependence as a strong "urge to smoke" and irritability when unable to smoke. The subject gave the following reasons for his current desire to cease using cannabis: 1) he felt he had simply "had enough", as he knew that he was using cannabis in order to avoid dealing with life's problems and at this age he felt he should be doing better things with his life; 2) he was concerned about the long term effects of cannabis upon mental functioning, having himself noticed difficulties with concentration, memory and motivation.

The subject had a minimal history of alcohol use, drinking at the level of two cans of beer per month for the past 15 years, and he currently smoked tobacco at approximately 10 cigarettes per day. He had dabbled in some experimental drug use between the ages of 18 to 21 (eg. amphetamines, cocaine, LSD) but had not used any drugs on a regular basis since that time. He was diagnosed as having Cannabis Dependence, without physiological disturbance, on Axis 1 of DSM-IV. He had completed 11 years of formal schooling and a trade certificate and was currently employed in a managerial position in the field of marketing. His full-scale IQ assessed by the NART was 120.

Apart from the initial diagnostic interview and drug history, a number of psychometric instruments were administered routinely throughout the treatment and at follow-up. Global functioning was assessed using the Health-Sickness Rating Scale (HSRS) (Luborsky, 1962; Luborsky, 1975), and the Symptom Checklist 90-R (SCL-90-R) (Derogatis, 1970). Depression was assessed by the Beck Depression Inventory (BDI) (Beck & Steer, 1987; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), and anxiety by the State-Trait Anxiety Inventory (STAI). Depression and anxiety are common in drug using populations and are important to monitor over the course of withdrawal. A number of qualitative measures were also administered to assess commonly reported problems and withdrawal symptomatology such as cravings, sleep disturbances, and headaches.

The initial levels of the objective measures of psychological status indicated that the patient was generally distressed and unhappy. On the HSRS he was rated 67 on the 100-point scale, indicating that he was functioning reasonably well but with the presence of mild to moderately disturbing anxiety and depression. His SCL-90-R global severity index of distress (GSI score) was 0.57 (63rd percentile) which indicates a level of functioning non-significantly worse than the mean (0.33) of the normal adult male population. On the BDI his depression score was 18, indicating significant clinical depression, well above the accepted cut off of 13. His anxiety was also elevated, with trait anxiety at 42 (68th percentile). His state anxiety at the time of initial consultation, however, was relatively low at 30 (28th percentile), indicating that he felt comfortable in the clinical setting.

The patient quit cannabis after the first three sessions of psychotherapy. Sessions were on a weekly basis. Changes in state anxiety and depression were monitored over the course of treatment and appear in Figs. 1 and 2. State anxiety reached a peak on the day following cessation of use, which coincided with a major argument in his relationship (score of 40, 70th percentile). Anxiety fell off in slow increments over the week following cessation and was continuing to decline three weeks later. The patient clearly responded quickly to the onset of treatment with his depression score falling into the mild range (above 7) immediately following cessation, and dropping further to a non-significant level at three weeks post-cessation. This suggests that the depression may have been partly induced by his substance abuse. Changes in overall psychological functioning were consistent with the changes in anxiety and depression. His HSRS rating three weeks after cessation was 87, indicating good overall functioning. Similarly, his SCL-90-R GSI score was 0.14, (48th percentile) which indicates low distress from symptoms.

Figure 1 : Changes in Anxiety Over the Course of Treatment

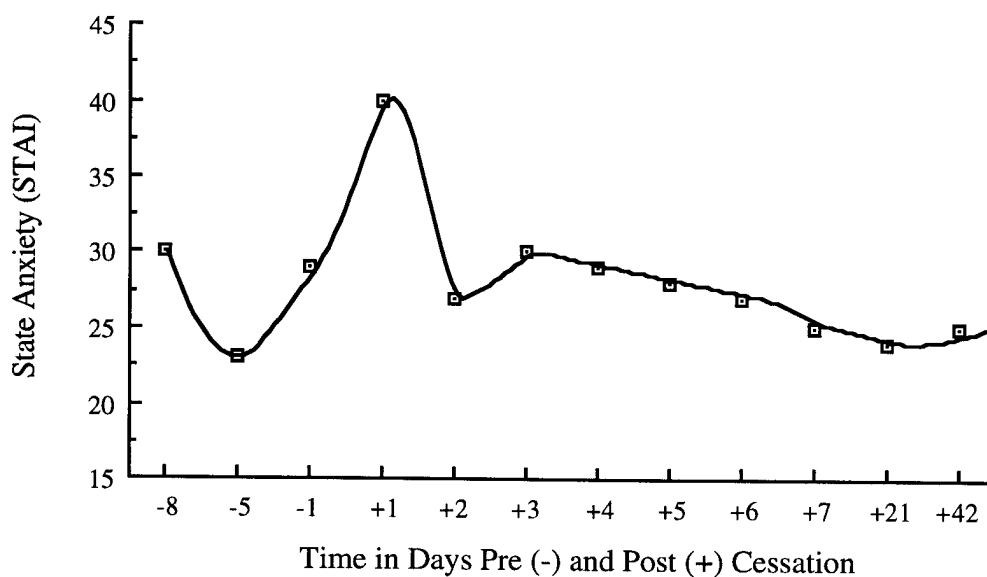




Figure 2 : Changes in Depression Over the Course of Treatment

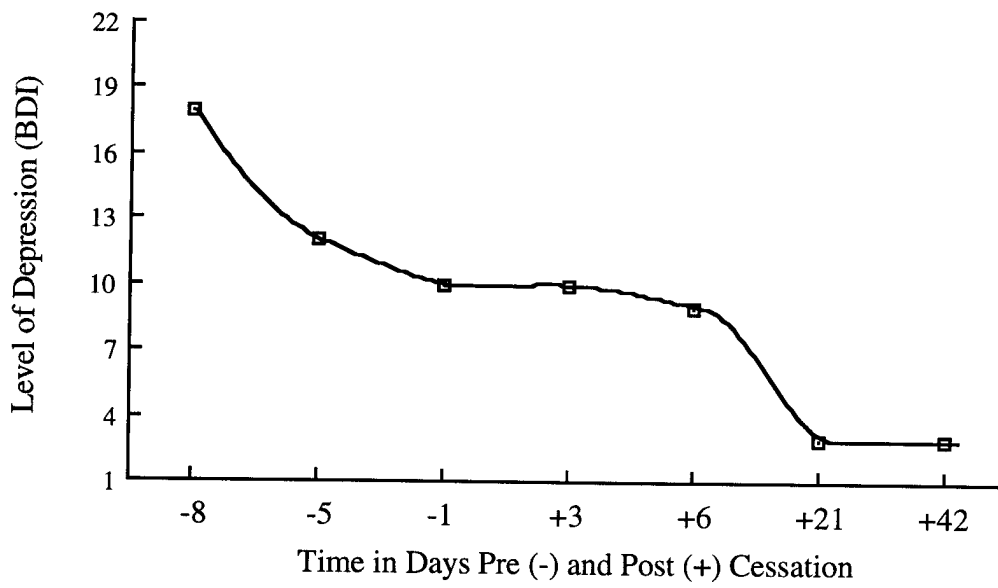
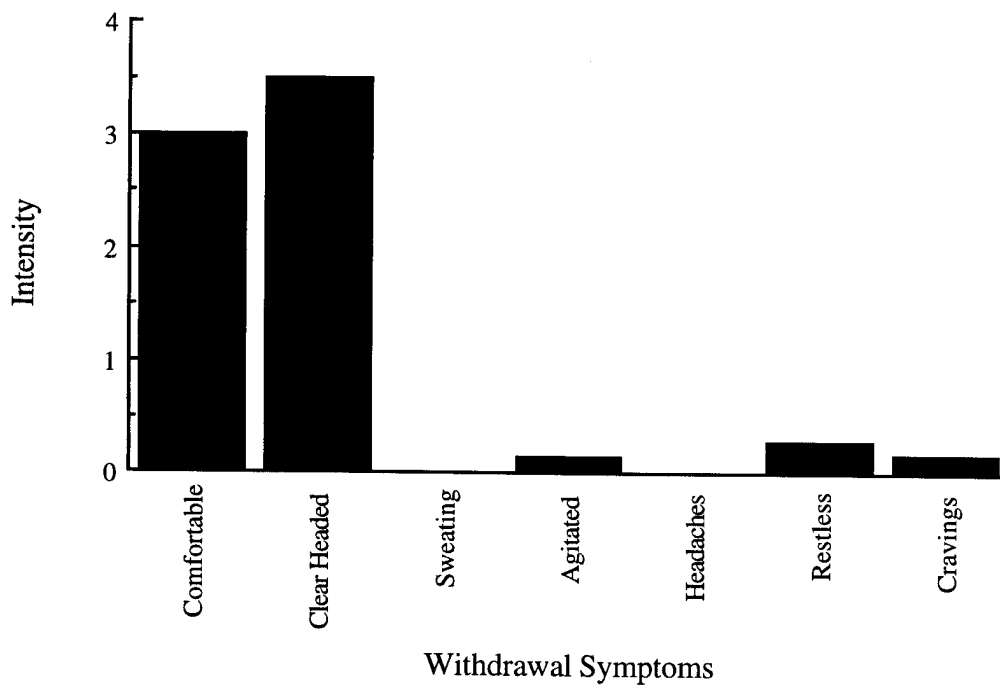


Figure 3 : Mean of Withdrawal Symptoms over 7 Days post Cessation



The qualitative assessment indicated that the patient did not experience any major physical withdrawal effects from ceasing cannabis use - a surprising finding. Cravings for cannabis monitored daily over the first week of cessation were consistently recorded as "not at all"; nor were there any reported problems with sleep, cloudy/foggy thinking, or somatic symptoms such as sweating, shaking or nausea (Figure 3).

The subject was successful in ceasing his cannabis use with the aid of the supportive-expressive psychotherapy he received. The major difficulty that this patient faced from ceasing cannabis use occurred in the area of his personal relationships. A number of major arguments with his (cannabis using) partner ensued resulting in turmoil in his personal life which threatened his resolve to quit. Some weeks after quitting he stated :

Ah I've ah, in the last, I suppose, three or four weeks felt a lot, ah, normal is not the right word, I have been able to see more clearly patterns and things that have happened in my life over time and ah, the fog that I spoke of earlier has lifted, so to speak. I don't pull bongs to avoid thinking about situations. And not avoiding thinking about situations and trying to question myself and others has lead to a few problems between me and my spouse.

Supportive-Expressive therapy was very useful for helping the patient through these periods as it focuses on interpersonal conflicts and the way these relate to the use of drugs. Cannabis had been consistently used as a way of avoiding these problems, or as the subject put it: "dope is like not having to do the washing up - after a few bongs it is as if the dishes are done". It is also of interest the analogy that this client uses with 'fog' - that cannabis clouds thinking and that these clouds are used to "avoid thinking about situations". In this sense the use of cannabis is consistent with the model of drug use that states that drugs are used to self-medicate for mental distress and problems.

It is of importance that this patient stated after a week of abstinence that he was 'now just beginning to see my 'sea of thoughts' which I have been adding to, and not really resolving or integrating since 18' years of age. The commencement of regular cannabis use from the age of 17 coincided with an important developmental stage in emotional maturity, which encompassed finishing school, establishing independence from the family home and the development of mature relationships. For the duration of his heavy use, these milestones had not been realised, with a long succession of unsuccessful attempts at finding a career path, unhappy relationships, dependence on his parents financially, and a generally itinerant lifestyle consistent with this pattern. His awareness of the sense of wasted time passing was symbolised by his wish to have some hair samples of his analysed :

Very keen to get the hair analysis done. Because I have got lots of it there to do and in fact I have hair that I, when I first ah, did a big chop of my hair when I was 23 or 24 I still have some of that hair sitting in a box, and every time I open

it up and look at it, which is very rarely I might add, uh, I it, it's like I am looking at myself. I really freaks me out to look at, hold in my hand my hair from 10 or 12 years ago and think 'christ this is .. you know I, I do feel as though I am looking at me. It is still a part of me. It shows that I wasn't quite as grey then. But ah, but I've been going grey for a long time.

The fears about his hair going grey provided a pivotal symbol motivating him to reassess his drug using lifestyle that has been inhibiting his personal growth. He was literally feeling that it "freaks me out" the passage of wasted years.

The following two extracts from the therapy provide some indication of the patients Core Conflictual Relationship Theme patterns :

I remember when I was ten I always wanted to play monopoly with my sister. She was 20 years old and didn't ever have have time to play with me. I felt really left out of things so I just ignored her.

I always felt like a latch-key kid when I was young. My mother, after having kids, went back to work and then I came along. I think I was a mistake. And she had decided that she wasn't going to stop work. And so I grew up artificially quickly, having much older brothers and sisters around me. But I always came home to an empty house from school and had to let myself in with my own key. I didn't have much to do with the others.

The CCRT pattern is :

Wish = to be close, to get attention

Response of Other = are distant, don't have time

Response of Self = feel unloved, alone, rejected and I withdraw.

The CCRT summary formulation is "I want to be close to people, but others don't have time, so I feel alone and withdraw".

In therapy this sense of others not having time and his withdrawal from (or lack of commitment to) relationships became central issues. The patient questioned how much time the therapist was prepared to give - and the end of sessions were always difficult for this patient (he often began long complicated narratives just before the sessions was finished). This became an important issue for the therapist in terms of maintaining the frame of therapy. He also started to realize that he himself was avoiding interpersonal relationships because of his expectation that others will not have time. Towards the end of therapy his cessation of use coincided with him reaching out to others more, particularly his family :

Ah, I am on a slightly better relationship with the family too because of it (cessation of cannabis use). Ah the family sort of knows what is going on vaguely, and it's been better for me to relate to some of my older brothers and

sisters, who've, I've started communicating with a little bit more over the past month or so, when I really haven't had any contact with them for a long time previous.

He was also able to establish stronger attachments to his step son, but was still having problems with commitment to his spouse :

Ah, we are still trying to organize what we are going to do in the long term - my spouse and I find it very difficult to lay the cards straight out on the table, and organize a commitment to each other even though I am committed to her son, ah much more so than we are committed long-term to each other because of course, he is a kid and takes attachments quite easily, and I feel very attached to him.

By the end of therapy, the patient had begun to feel more settled within himself and his relationship and work, and now felt that he could "catch up" on all the maturational progress he had missed over his 18 years of use. An unexpected feature of ceasing cannabis use was the way he then began to project harsh feelings and criticism on those that were still using drugs. In particular, the drug users' inability to organize themselves received particular criticism. This was of interest because the characteristics of these people that he had most disdain for were those aspects that were similar to him when he was a user. Early in therapy he stated :

Ah, I am still, still smoking cones in the evening, and ah, it's not a problem at all. (laughing) Smoking cones in the evening, in fact it alleviates all the problems of the day. You seem to be able to put everything behind you and have a good laugh. A classic scenario, I forgot the first two days to do a task. (laughs) and ah, the second day I did remember and did it and, ah then unfortunately this morning with a slight relationship hiccup I forgot again. So I haven't really got that off the ground until tomorrow.

In talking about his work colleagues late in therapy (after cessation), he stated :

So staffing at the premises I am not at all happy with. And although I have made one or two mistakes, the young twenty four year old who works there - the guy - ah is unfortunately goes out and gets pissed every night and I am sure he smokes and takes any thing else that comes his way. And of course looks good when he is in at work, but can't follow through on things and doesn't get organized and so forth and so he has been a bit of a problem.

The changes in perspective about drug use and users can be quite polarized as the user quits. A feature of this treatment approach is its flexibility in responding to the patient's individual needs. Therapy content is not prescribed, but leaves the content of what is discussed open to the patient to use as his needs dictate. The basic support and listening skills inherent in the approach help the patient to achieve the goals of abstinence and also are available to address any broader life problems as they impinge upon the patient's sense of mastery and psychological health.

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## 10. Summary of the structure of a 16 session time-limited treatment

This guide is only one of many structures of treatment that could be used. For example, the time limit might be 26 sessions, the user might want to quit after the second session. It may be that expressive techniques can be used from the first session. The assessment and the therapeutic decisions of the therapist and patient will determine the ideal structure. Page numbers refer to discussion in the text.

### *Pre-therapy assessment*

Diagnose using DSM-IV criteria. Clinical assessments. Give pre-therapy socialization interview (p. 30). Assess variables relevant to matching patient with therapist.

### *Session 1*

Assessment of goals (p. 9). Establish the frame of therapy (p. 27, 30).

### *Sessions 2-3*

Make CCRT formulation (p. 19). Prepare patient for quitting (p. 21, 24). Establish supportive relationship (p. 13).

### *Sessions 4 - 5*

If patient quits, monitor withdrawal (p. 21). Primary supportive techniques. Continue with CCRT focus.

### *Sessions 6 - 12*

Exploration of CCRT patterns using expressive techniques (p. 14). Focus on interpersonal relationships and psychosocial maturity (p. 22).

### *Sessions 13-16*

Preparation for termination (p. 36). Continue with CCRT focus. Focus on gains. Focus on reinforcing mastery. Focus on problems with relapse.



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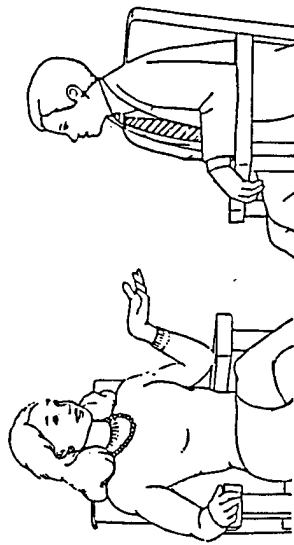
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## **Appendix 1 : Psychotherapy Socialization Leaflet**

This can be a useful leaflet to hand out at the initial assessment interview to help orient the patient to psychotherapy treatment. The basis behind the socialization interview is given in Orne and Wender (1968) and is also described in Luborsky (1984). This handout has been adapted from these guidelines.

# About Psychotherapy



## About Psychotherapy

This is designed to tell you a little about what psychotherapy is and what happens in psychotherapy. Your therapist will be happy to explain anything you do not understand. Just ask. Firstly, it is important to realise that psychotherapy is different from counselling. Many people expect to tell the therapist about his or her problem and that then the therapist will give advice which will solve everything just like that. This is not true; it just does not work like that. Before you came to therapy you may have got advice from all kinds of people: your spouse, your parents, your friends, your family doctor, and so on. Many of these people know you quite well; some of them know you very well; and if it were just a question of getting advice there is no reason to think that your therapist would be much better at it than all of the people who have always told you what to do. Unfortunately, when people give advice, they usually provide solutions which will work for themselves but not for the person who has the problem. If all of the advice you have received had helped, the odds are that you would not be in therapy. The therapist wants to work with you in trying to explore and understand your difficulties and concerns.

What does this mean? Well, if your therapist sees you getting into some kind of trouble, he or she may warn you about it, but here again the final decision as to what to do will have to be made by you. The great advantage you will have with your therapist is that he or she has no axe to grind. The therapist does not

think he or she knows what is best for you, but is going to help you try to find out. The therapist does not think that he or she knows the answers but rather, he or she just wants to understand, with you, why you do things. The other point is that your therapist is bound by the ethical rules and standards of their profession. Your therapist will treat everything you say with respect and will ensure complete confidentiality.

What goes on in therapy itself? What do you talk about? What do you do? How does it work? Often you will talk about your needs and wishes both now and in the past. Usually people do not talk about a lot of things because they are too personal, or because they would hurt other people's feelings, or for some other similar reason. You will find that with your therapist you will be able to talk about anything that comes to your mind. He or she won't have any preconceived notions about what is right or what is wrong for you or what the best solution would be. Talking is very important because the therapist wants to help you find out what you really want. The problem most people have in making decisions is not that they do not know enough, but that they never have had the opportunity of talking things over with someone who does not try to make their decisions for them. The therapist's job is to help you make the right decisions.

Often we are confused about ourselves. The therapist is not going to try to tell you what he or she thinks, but may point out to you how two things you are saying do not seem to fit together. The job of your therapist is to help you keep

in mind all of the important facts and feelings so that you can come to a solution that takes all of the facts into account. This is sometimes hard because these feelings may often conflict with each other.

You have probably heard that psychotherapy works with the unconscious parts of the mind. What is really meant by that? The unconscious is not a mysterious thing. For example, you have probably met people who seem to annoy you, and make you angry, but you cannot work out why. It may be that this person reminds you of someone but you do not realise it. The person who he or she reminds you of is someone with whom you are angry, so you find yourself taking it out on the person at hand. Unless you can remember whom you really are angry at, it can be hard to get over your feelings of annoyance. In this case, becoming aware of what is unconscious involves remembering and recognising the difference between these two people. Sometimes, though, it is an awful lot of work to work this out.

When we are not aware of the reason for a strong feeling like this, a therapist might then say this is unconscious. By becoming aware of the reasons for our anger with someone, we can treat him or her on a more realistic basis. It is the therapist's job to help you recognise when the feelings you have toward someone seem to be inappropriate and to learn to understand the real causes.

When you start treatment, you will find that some of the people closest to you, who have encouraged you to get help,

may change their mind and decide that therapy is not helping you. This is often an indication that you are changing and that these changes are puzzling and troublesome to someone close to you. You should know that almost always in treatment some of the people around you will be convinced that you are getting worse - often just at the time when you feel you are really improving. And you yourself might also sometimes feel worse and discouraged at some stages of therapy. You might feel you are not getting anywhere, your therapist does not know what he or she is doing, and there seems to be no point in this, and so on. These uncomfortable feelings are often good indications that you are working on difficult problems. It is very important that you do not give in to these temporary feelings when they come up. You will soon find yourself making good progress again.

What might also happen, as you talk about more difficult things, is that you may find yourself having trouble keeping your appointments. You won't be able to get away from work, there will suddenly be necessary overtime just at the time of the appointment, your car will break down, your family will need your help at home for something, and so on. All of these things will seem quite unrelated to therapy. The important point is that these problems suddenly seem to crop up at the same time you are getting down to something difficult and important in the therapy. These are the most important times to make sure you come to the therapy meetings. The only way to protect yourself is not to allow yourself to judge how important any given therapy session will be, but

instead to decide beforehand that you are going to be there, no matter what comes up.

In other words, if you make an appointment, you will keep the appointment regularly. This does not mean that you cannot postpone a session for good reason, if you discuss it with your therapist beforehand. For example, if you know three or four weeks in advance that you have got a business trip, and you know it is something you have to do, it won't, as a rule, interfere with treatment if you miss an appointment. It is the sudden emergencies which are almost always unconsciously planned - things that come up unexpectedly.

Another thing - in treatment you will often find yourself feeling uncomfortable. For one thing, your therapist won't say a great deal and you will find yourself trying to make decisions about what to say. We do this all the time. If we did not, we would get ourselves into a lot of trouble. If you think your boss is an idiot and you told him or her this, you might lose your job. In general, we have to make a distinction between what we think and what we say. In treatment this is not so. In therapy you say whatever comes to your mind, even if you think it is trivial or unimportant. It does not matter. It is still important to say it. And if you think it is going to bother your therapist, that does not matter either; you should still say it. In contrast to your boss, if you think that your therapist is an idiot, you need to tell him or her about it. You will find this is very hard to do and yet it is one of the most important things to learn in therapy

- to talk about whatever comes to your mind. Often what you think is trivial and unimportant is really the key to something very important.

For example, you might suddenly become aware that the room is hot or that the therapist's clothes are awful or something like that which seems both trivial and even perhaps a little rude to bring up. Yet, in treatment, if you think of it, you say it. Often such things turn out to be very important. So just like the appointments, we make an absolute rule that you should not think ahead about what you will say and therefore protect yourself from facing important things. Say whatever is on the top of your mind, no matter what.

After some time in therapy you will start to feel like you have achieved your goals and that you feel a lot better. It is best for you to discuss these feelings straight away with your therapist. It is important for you to set aside two or three sessions at the end of therapy to check your feelings before you do finish. This will help to make the ending between you and your therapist a good one. It is best if you do not suddenly leave therapy as just the act of bringing up important material and leaving it unresolved can be quite damaging. Therapy can be a wonderfully enriching experience. I wish you well. Remember to discuss any problems or things you do not understand with your therapist. They are there to help you.

Adapted by Brin Grenyer, University of Wollongong, Australia, from the guidelines of Orne and Wender (1968) American Journal of Psychiatry. © 1995

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## **Appendix 2 : Example of a Patient Information Leaflet on Quitting**

Leaflets such as the following example (Grenyer, Solowij & Peters, 1995) can be made available in the waiting room. Leaflets similar to the following are now widely available for most of the common drug and alcohol problems and are also available for psychiatric disorders. This is the first produced specifically for cannabis dependence. Although these leaflets have no formal role within SE psychotherapy, they may be of passing interest for some users trying to quit.

# MARIJUANA

## A GUIDE TO QUITTING

1

### MARIJUANA: A GUIDE TO QUITTING

#### Taking action to quit cannabis use

This guide is aimed at assisting people who are seriously considering quitting the use of cannabis and need some help to do so.

#### About cannabis

Cannabis is the general name given to a variety of preparations derived from the plant *Cannabis sativa*. Other names include marijuana, grass, dope, pot, weed, mull, hash, hash oil etc. The main psychoactive ingredient in cannabis is delta-9-tetrahydrocannabinol or THC.

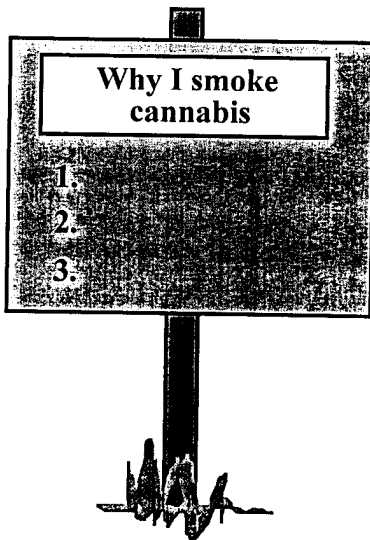
#### How does THC affect me ?

When cannabis is smoked, THC quickly absorbs into the bloodstream through the walls of the lungs and is taken to the brain. The amount of THC entering the bloodstream depends on the potency of the cannabis used. When eaten, THC entry into the bloodstream is much slower, but the effects last longer.

### WHY DO I SMOKE DOPE?

There are many reasons why people smoke cannabis. It is helpful if we try to identify your reasons for getting stoned. This will give you an idea of how to achieve a similar result through other activities when you stop. For example, some people smoke to help them relax. There are many other ways of relaxing without smoking, like meditation and bushwalking. Others smoke to enhance conversation and social interactions, but many find that after several years of smoking the quality of relationships and social life in general can deteriorate. Another reason for smoking is to avoid having to deal with life's problems. However, the problems just don't seem to go away by themselves. In the space provided try to identify your reasons for getting stoned. Be specific, but don't try to narrow it down to one reason only.

2



### WHY GIVE UP?

There are many reasons for giving up. The following have been identified by users, ex-users, researchers and health professionals. These include health reasons, social reasons, legal and financial reasons. Examine these reasons and decide how relevant they are to you.

#### Health risks

Research shows that the long-term use of cannabis leads to:

- respiratory diseases such as chronic bronchitis
- changes to cells in the body which may signal the development of malignant tumors
- problems with attention, concentration and memory which get worse with continued use of cannabis and only partially improve upon quitting.

3

#### Other possible problems include:

- an increased risk of developing cancers in the aerodigestive tract (e.g. mouth, throat, larynx, lung)
- an increased risk of birth defects or leukemia in children exposed to cannabis during pregnancy
- poor educational achievement and difficulties in learning
- an increase in symptoms of illness in persons who suffer from heart disease, asthma, bronchitis, emphysema, schizophrenia

Identify the health consequences of cannabis use which present the most cause for concern to YOU:

#### My Health Fears: 1.

2.

3.

#### Social reasons for quitting

Some people want to give up because they are tired with their current lifestyle and feel they are stagnating. Does the following apply to you?

- I am worried that my social life is becoming restricted to only dope smokers.
- I have been feeling low and have been avoiding people.
- My relationships with some people are not going well.
- I am upset by arguments and conflict between my partner and me.
- My partner is concerned about my smoking.
- I have been worried about smoking around children.

Many people use cannabis to avoid dealing with these problems. Often such problems just continue to get worse. Your decision to quit might make some problems seem worse in the short-term, but you will end up feeling much better about yourself and your life in the long run.

Remember: "no pain, no gain".

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**Adding up the costs**

Are you concerned about the amount of money you are spending on cannabis? Complete the table below and calculate what getting stoned is costing you per year.

Cannabis (e.g. leaf, heads, hash)

\$..... per week x 52 OR \$..... per month x 12

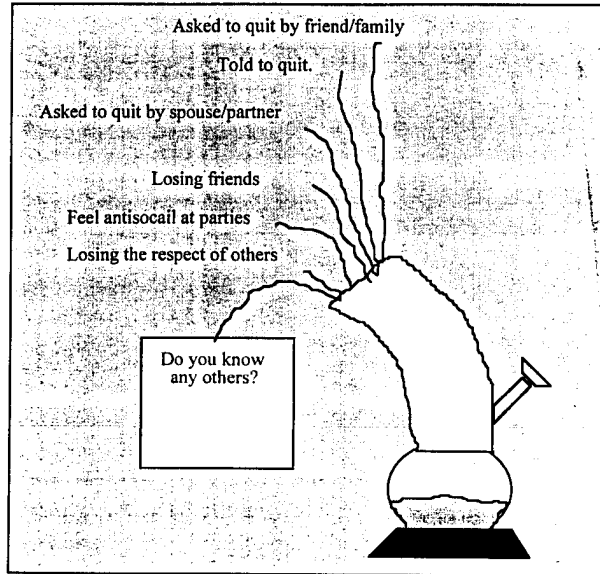
Total costs per year \$.....

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

**Other hassles about cannabis ...**

We have talked about how cannabis can affect your health, social life and pocket. What about these other hassles? Do these worry you?

- Feeling addicted or not being able to control my use of cannabis
- Not doing my job properly anymore
- The dangers of driving when stoned
- Wasting time trying to score
- The risks involved in growing my own
- Getting busted by the cops
- Arrests, fines, court hearings, possible criminal record and other legal hassles.



**HOW DO I GIVE UP?**

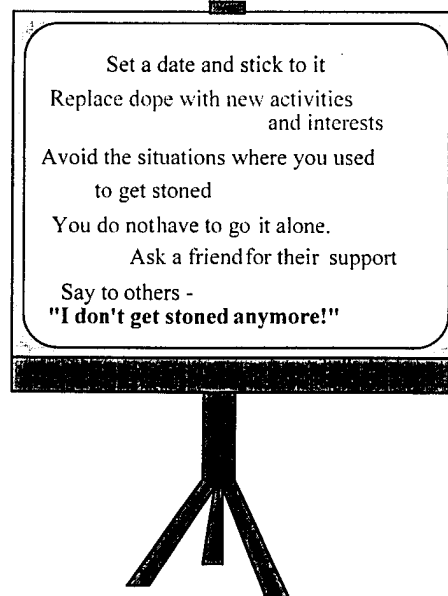
Most people who are successful in giving up do so "cold turkey". That is, they simply stop using one day and don't go back to it. Some people try to give up gradually by cutting back on their use. This can sometimes work but it can also prolong the agony. People that cut down sometimes rapidly return to heavy use. If you are serious about quitting, the best way is usually to simply stop. Soon after quitting you will find that your thinking starts to become clearer.

**Changing my old habits**

When you use cannabis you are establishing a link between the situation and getting stoned. This means that certain situations, people and places, which were present on a number of occasions when you smoked may, in the future, trigger your desire to get stoned. In the space provided list the places where you usually get stoned, other persons present, your mood just prior to getting stoned. This need not be based on your memory of previous sessions. It might be useful for you to fill this in right up until you decide to quit. A final item you can include, is a possible substitute for getting stoned that is appropriate for the situation.

Where	Who with	Mood	Substitute

The following strategies may prove useful to you in quitting.



From the previous illustration you should be able to identify a number of strategies you can use to help you quit, especially in the initial stages. All of these may be useful at some stage or another.

In order to quit using cannabis you have to confront your own desire to get stoned. You will essentially be going into battle against a part of yourself that you no longer wish to exist. Giving up cannabis, especially if you have been using regularly for some time, is a bit like losing an old friend. But giving up should not feel like a funeral, but a beginning of your new life. Do not get upset about quitting - think of it as a positive step for the better. For this reason you must be well prepared and have a plan worked out well in advance. If you follow some of the steps suggested in this guide you will find it easier to achieve your goal. If you are serious about stopping, it is now time to decide when you are going to quit.

### A CONTRACT WITH MYSELF

I promise that I shall go into battle to quit using cannabis on:

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

"Our greatest victories and those which are most enduring are our victories over ourselves"

(Napoleon)



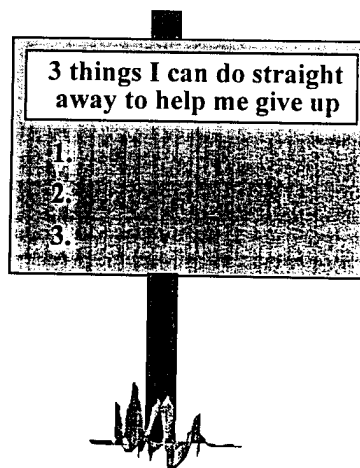
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### My decision

Set a date which you designate as Quit Day. Give yourself at least one week of preparation before Quit Day. Remember that the decision is yours and the commitment you make to quit cannabis is with yourself. It may be helpful to make a contract with yourself to formalise your plan and to remind you of your commitment.

### Strategies to help me quit

We discussed at the start of this guide why you get stoned. Now try to think of some things that you can do that you know will help you when you give up.



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### A check of my feelings

On the day that you give up, and for a week or more after, some people can feel out of sorts. There are a number of "withdrawal symptoms" caused by stopping regular use of cannabis. These are some of the things you might experience :

- anxiety
- moodiness
- irritability
- tremors
- perspiration
- nausea
- sleep disturbances.

These are a normal part of giving up. Your body is flushing out the cannabis toxins. Take it easy, stay with your resolve to quit, and these feelings and problems will soon go away.

### HOW DO I STAY OFF?

Once you have set a date and you have made the initial steps toward quitting, you will experience times when you want to break your contract. Falling back into your old habits is one reason why people fail in their attempts to quit. It may be helpful for you to alter your lifestyle to accommodate the new you without cannabis.

### Lifestyle changes

It is often useful to make other changes to your lifestyle in order to be successful in quitting cannabis. Think about what you are going to say to your old friends that you used to smoke with. It might be helpful to practice saying things like "I don't smoke anymore" or "I have given up dope". Change your diet to include healthier food. Set new routines - like increasing exercise. If stress is a major issue for you then learn stress management techniques other than getting stoned, or do your best to avoid stressful situations. Work hard to improve your relationships. Make efforts to meet new people. Try to find new meaning in your life without cannabis.

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### Anger and Frustration

Anger and frustration can lead to strong urges to get stoned. In some situations these feelings can stem from withdrawal, but more often they occur in the presence of your cannabis triggers - like having problems with other people. When you feel the urge to get stoned, try not to get caught up in the feeling (e.g. "I would die for a bong"). Practice being detached (e.g. "I feel the urge because I'm frustrated and it will soon pass"). Every craving you survive puts you closer to your goal.

### Avoidance

Avoid situations that are likely to cause you to relapse. For example, if going to parties where people smoke is going to be difficult, try avoiding parties for the first couple of months after quitting.

### Escape

Take a break from situations where other people are smoking or about to smoke dope. A brief walk or other activity can help you in your quest to give up.

### Remind myself why I gave up

It is often a good idea to remind yourself why you gave up. Re-read this guide and think about your reasons for quitting when you feel you might be getting into a situation that might lead you to smoking pot.

### Notice how many people don't smoke

Tell yourself frequently that you now choose not to smoke. Think of yourself as a caring, responsible person, and that you do not want to pollute your body or the environment.

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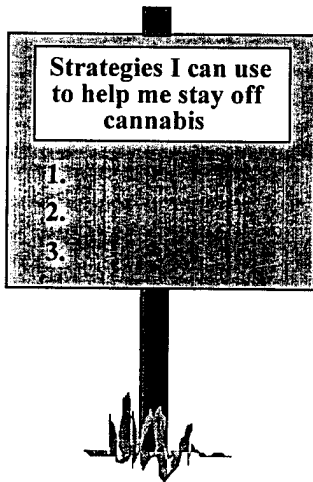
### Have someone listen

Let someone listen to you when you need to talk about your change in lifestyle without cannabis. Let someone 'reward' you for not smoking.

### Cleaning up my life

Remove all the things from your home that remind you of cannabis smoking. Consider how the world around you will be a better place if you don't smoke. Remind yourself that many people have successfully given up and have been able to deal with their problems without cannabis.

In the space provided try to identify some strategies which may help you to stay off.



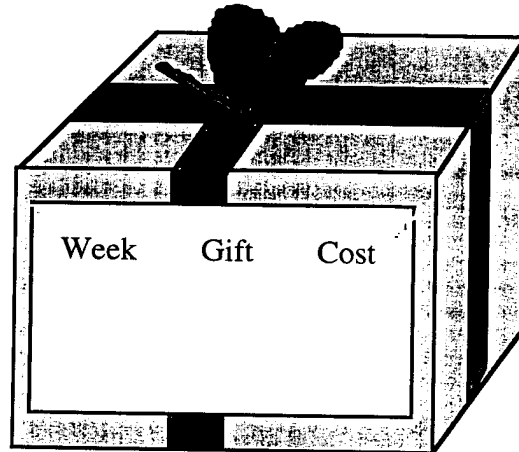
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### Lapses

Sometimes you will not be able to fight the urge to get stoned. If you do slip up on your contract do not fall into the trap of labelling yourself as a failure. Consider it a lapse in concentration - act quickly as you will still have time to return to your contract. If the same situation keeps getting you down, then approach it in a different way. It is a good idea to remind yourself that you are confident and capable of not smoking. Don't get upset about quitting.

### Rewarding myself

Make sure you have some pleasures in life. One good suggestion is to reward yourself with a gift at the end of each week that you are successful in fulfilling your contract. Try to match the cost of the gift with the average weekly cost of getting stoned which you calculated earlier. You may like to keep a record of this in the table below:



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### VICTORY! CONTRACT FULFILLED

"Desire is the key to motivation, but it's the determination and commitment to an unrelenting pursuit of your goal that will enable you to attain the success you seek" Mario Andretti (race car driver).

Quitting cannabis is like learning a new skill. The more effort you put into it the more skilled you become. Apply yourself to the task and you will notice an improvement. If you feel pressured into getting stoned, remember that it was a thing of the past and you no longer need it.

Here are some comments by people who have given up.

"I gave up because I was in a rut. It was easier than I thought."

"My friends and work mates have noticed how much happier and positive I am now that I have given up."

"I have more time now to enjoy my friends and family."

"I have some funny memories about getting stoned. I sometimes miss it but I would not go back to that lifestyle anymore."

"I hated going out to buy grass, it wasted so much time and money. I don't worry about this now."

"I felt myself getting paranoid and withdrawn everytime I had dope. Now I actually talk to people at parties and enjoy getting into conversations."

"Dope used to be my big excuse for not doing anything in my life. Now I have given up my mind is a lot clearer. I see things in a new way."

Why not write and tell us how you went ?



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## MARIJUANA: A GUIDE TO QUITTING

This pamphlet is designed to assist those people who wish to quit using cannabis and require help to do so. It illustrates:

- \* Why you should give up
- \* How to give up
- \* How you can stay given up

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