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Supportive-expressive psychotherapy for cannabis dependence

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Supportive-expressive psychotherapy for cannabis dependence

Abstract

Supportive-expressive (SE) dynamic psychotherapy forms one variation of a number of psychotherapies that emphasize the importance of effective interpersonal relationships for psychological health (Grenyer, 2002a). The overall goal of SE psychotherapy is to help the client achieve mastery over their difficulties, gain self-understanding, and practice self-control over habitual drug use and related problems. From this framework, cannabis dependence is understood within the context of the client's interpersonal relationships, work, and social problems. The theory behind the SE approach emphasizes the formative influence of life experiences on the development of personality and on the genesis of problems, including habitual cannabis use. Change is brought about through mastering (understanding and controlling) 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 client and therapist. The therapist maintains this framework by focusing on the client's goals and fostering an understanding of relationship conflicts as they interact with conditions for drug abuse.

There is evidence that supports the SE approach to understanding and treating cannabis dependence. Cannabis dependence may adversely affect interpersonal relationships (Solowij & Grenyer, 2002a). Heavy use during adolescence may produce a developmental lag, entrenching adolescent styles of thinking and coping which can impair one's ability to form adult interpersonal relationships (Baumrind & Moselle, 1985; Kandel & Logan, 1984; Kandel *et al.*, 1986).

Keywords

Supportive, expressive, psychotherapy, for, cannabis, dependence

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

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Supportive–Expressive Psychotherapy for Cannabis Dependence

BRIN F. S. GRENYER AND NADIA SOLOWIJ

Supportive–expressive (SE) dynamic psychotherapy forms one variation of a number of psychotherapies that emphasize the importance of effective interpersonal relationships for psychological health (Grenyer, 2002a). The overall goal of SE psychotherapy is to help the client achieve mastery over their difficulties, gain self-understanding, and practice self-control over habitual drug use and related problems. From this framework, cannabis dependence is understood within the context of the client's interpersonal relationships, work, and social problems. The theory behind the SE approach emphasizes the formative influence of life experiences on the development of personality and on the genesis of problems, including habitual cannabis use. Change is brought about through mastering (understanding and controlling) 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 client and therapist. The therapist maintains this framework by focusing on the client's goals and fostering an understanding of relationship conflicts as they interact with conditions for drug abuse.

There is evidence that supports the SE approach to understanding and treating cannabis dependence. Cannabis dependence may adversely affect interpersonal relationships (Solowij & Grenyer, 2002a). Heavy use during adolescence may produce a developmental lag, entrenching adolescent styles of thinking and coping which can impair one's ability to form adult interpersonal relationships (Baumrind & Moselle, 1985; Kandel & Logan, 1984; Kandel *et al.*, 1986). A high rate of relationship failure is predicted by a strong correlation between drug use, precocious sexual activity, and early marriage. Studies have shown that a high degree of involvement with cannabis predicts a 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

(Fergusson & Horwood, 1997; Newcombe & Bentler, 1988). It has been suggested 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, 1988, pp. 35–36). In addition, habitual users are more likely to have a social network in which friends and partners are also cannabis users. Many chronic cannabis users appear socially and occupationally functional on the surface. Upon cessation, however, 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; Hall & Solowij, 1997). This suggests the need for a treatment approach that not only focuses on modifying drug use, but also on the interpersonal sequelae in relation to psychosocial development (Solowij & Grenyer, 2002b).

A study of 150 adult heavy cannabis users (Hendin *et al.*, 1987) found that approximately two-thirds of the sample was in a steady relationship, but only half of these were described as satisfactory. Difficulties in relationships with parents were also apparent. Cannabis users' most frequently reported psychological problems concerned feelings of insecurity, low self-image, extreme introversion, depression, and relationship problems. The latter were described variously as serious dissatisfaction with their current relationships, fears of intimacy and commitment, and a lack of meaningful relationships. Less than 5% saw drugs as the primary cause of their problems. The elevated levels of depression and anxiety among cannabis users may increase during the course of withdrawal from cannabis (Kouri & Pope, 2000). The focus of SE psychotherapy on the whole person's personal and interpersonal functioning, including the role of drug use, makes this approach particularly suitable for the cannabis user.

Empirical Bases

SE dynamic therapy originated in Freud's papers on technique (e.g., Freud, 1914/1958), and was developed in the late 1940s and 1950s at the Menninger Foundation and Clinic, Menninger School of Psychiatry, Topeka, Kansas. The treatment is systematically documented in a manual (Luborsky, 1984) that includes methods for evaluating adherence to the technique. A number of specialized versions of the main SE manual are tailored towards specific drug dependence disorders (Barber & Crits-Christoph, 1995) including the following: opiate dependence (Luborsky *et al.*, 1995); cocaine dependence (Mark & Faude, 1995);

and cannabis dependence (Grenyer *et al.*, 1995). In addition to the manuals, a number of therapist training resources are also available, including a monograph on the clinical application of SE psychotherapy (Book, 1998).

This approach has been repeatedly and successfully evaluated over the past 30 years (Crits-Christoph & Connolly, 1998). For example, the Penn Psychotherapy Project (Luborsky *et al.*, 1988) evaluated the treatment on 73 mixed-diagnosis clients, and found a mean effect size of 1.05. It has been incorporated in the treatment of chronic and major depression with mean effect sizes of 1.80 and 2.75, respectively, on the Global Assessment Scale (Diguer *et al.*, 1993). It was a key component of the VA-Penn psychotherapy study of treatment for opioid dependence (Woody *et al.*, 1983, 1987), one of the largest and most successfully conducted studies of its type. In this study, SE psychotherapy plus drug counseling (DC) was compared to cognitive-behavioral therapy (CBT) plus DC, and DC alone. At 1 and 12 months, SE and CBT were essentially equivalent in effectiveness, and both were significantly superior to DC alone. A later validation study found SE to be more effective than DC for opiate-dependent clients receiving methadone in the community (Woody *et al.*, 1995). SE has also been compared to CBT in a large-scale collaborative study of cocaine abuse treatment (Crits-Christoph *et al.*, 1999). Again, there was no difference in effectiveness between SE and CBT, although neither treatment was as effective for this population as DC. To date, the literature suggests that SE dynamic psychotherapy is effective for treating some drug problems, and at least equivalent in efficacy to CBT. Its emphasis on interpersonal functioning suggests that it would be useful for treating cannabis dependence.

SE Psychotherapy Techniques

The term "supportive-expressive" refers to the two main treatment techniques of this approach. The therapist develops supportive techniques to create a positive, helpful, and empathic relationship with the client. The therapist uses expressive techniques to help the client express and understand problems, and ultimately effect changes. Sessions focus on identifying and interpreting the client's recurring problematic interpersonal relationship themes as they occur (a) with the therapist (transference), (b) in relationships with other people (e.g., partners, family, friends, and parents), and (c) around specific behaviors (e.g., drug taking), in order to find solutions to life problems. The Core Conflictual Relationship Theme (CCRT) method is used to help identify the recurring relationship patterns. The CCRT method (Book, 1998; Luborsky & Crits-Christoph, 1998) summarizes the client's core relationship problems, and guides the expressive component of

Figure 10.1 Components of SE treatment and outcome in terms of augmented mastery.

treatment. Helping the client understand the relationship between CCRT patterns and their drug use is a central technique of this method, and this promotes mastery (self-understanding and self-control) over their problems (Grenyer, 2002a). Figure 10.1 overviews the basic components of treatment – the supportive and expressive components, and the outcome in terms of mastery.

Supportive Techniques

The supportive techniques create a strong working relationship between client and therapist upon which the success of the treatment rests. Support refers to the establishment of a working relationship that is focused on helping the client strengthen competence, bolster esteem, achieve goals, and solidify their grip on reality. Support requires sensitivity, patience, and a genuine wish to help. The helping alliance reflects the degree to which the client experiences the relationship with the therapist as helpful in achieving therapeutic goals. The client's feelings of optimism and confidence that therapy and the therapist are being helpful constitute part of the therapeutic alliance. There is now a considerable body of research indicating that the quality of the helping alliance predicts therapy outcome (Martin *et al.*, 2000). Research suggests that, in particular, therapist respect, accurate empathy, warmth, and genuineness are necessary ingredients in forming a helping alliance (Beutler *et al.*, 1994). In short, the therapist must convey hope and optimism for their work, and show respect and an affinity for the client. Luborsky (1984) suggests that a "we" bond is fostered, and that it is helpful to refer to the experiences that the client and therapist have shared to underscore the theme of therapy as a shared collaboration.

Expressive Techniques

In contrast to the supportive techniques, expressive techniques are focused on understanding the client and helping them change. The four phases of the expressive task are outlined by Luborsky (1984) as (a) listening, (b) understanding, (c) responding, and (d) listening again. Listening can be seen as having three phases: (a) open inquiring listening, (b) listening to form hypotheses, and (c) listening to check the accuracy of formed hypotheses (Schlesinger, 1994). Listening allows the therapist to better understand the client, and in turn, governs how the therapist responds to the client. Via responding, the therapist communicates to the client information that has been understood through listening (e.g., "it sounds like your problems with your Dad really made you mad and it seems like smoking dope was a way of switching off from all that").

Identifying CCRTs

Formulating the main problematic relationship theme and its connection to cannabis use should be accomplished relatively early in therapy, as this forms a focal point for the remaining sessions. Also, it is particularly important to maintain a therapeutic focus in short-term therapy, and this focus should be centered around the CCRT. Research has shown that treatment outcomes improve when appropriate CCRT-focused interpretations are used judiciously in therapy sessions (Crits-Christoph & Luborsky, 1998; Crits-Christoph *et al.*, 1988). The CCRT technique (Luborsky, 1977; Luborsky & Crits-Christoph, 1998) involves the analysis of narratives told by the client which detail relationship interactions with close relatives or friends, the therapist, or the self. Within the narratives, one can find the "transference template"; that is, the client's regular characteristic conflictual personality style. The CCRT has three components: (a) the wish, (b) the response of other, and (c) the response of self. "The wish" refers to the person's needs and desires (e.g., to obtain love and nurturing). "The response of other" refers to others' reactions to the client (e.g., hostility or aggression). "The response of self" refers to how the client responds to others (e.g., withdrawing and becoming intoxicated with cannabis). The three elements of the CCRT influence the dynamics of therapeutic interactions, and illustrate the basic means by which clients attempt to satisfy their needs. They narrate the expression of a wish, how this was received and responded to by another person, and how the response of this other person, in turn, affected them. Research corroborates the frequently observed phenomenon that clients often repeat similar relationship patterns (CCRTs) with different people in their life, including the therapist.

Helping the client realize these patterns is the first step in teaching the client to take charge of their interpersonal interactions, and ultimately, to institute adaptive goal fulfillment strategies in place of the initial, less effective techniques. This process inspires clients to work towards achieving their goals and fulfilling needs in more effective and adaptive ways.

A therapist can deduce clients' central problems by observing repetitions of similar themes in different contexts, charting the relationship between one set of conditions and a corresponding set of predictable reactions, and constructing an exemplar of these sequences over multiple sessions. For example, a client may feel enraged and complain that one of his friends always takes advantage of him by smoking more than his share of the cannabis. At another time, the client may discuss how he is expected to visit his grandparents much more than his brothers and sisters. Later, he may talk about how the psychotherapy sessions are never long enough, and he feels like he is not getting the help that he deserves. These examples manifest the same CCRT pattern, which the therapist could illuminate by saying, "it seems like at many different times you have wished to be treated fairly, but you feel others have not done so, and you feel enraged and cheated by these things which has lead you to continue smoking." Helping the client see these patterns' roles in their life is a substantial step towards engendering adaptive responses (i.e., responses that do not incorporate drug use) to similar situations. The basic principles of the scientific method – observing causes and effects – informs the structure of listening and the ways to respond after listening. Responses by SE psychotherapists typically concern an aspect of the CCRT pattern, and when possible, relate this element to the emergence of a chief symptom (e.g., drug use, feelings of anger, states of helplessness). Within psychotherapy sessions, the therapist continually relates drug-using themes to the interpersonal context. The therapist educates the client about how difficulties in fulfilling their needs and wishes can reinforce drug use. Early in therapy, the therapist explains to the client that this treatment will emphasize not only ceasing cannabis use, but also helping the client more effectively handle interpersonal and personal triggers. The sessions, therefore, focus on the clients' current and past relationships, their CCRT patterns, and the role drug use plays in helping and hindering their goal attainment.

Dealing with Cognitive Deficits from Long-Term Use

Cannabis use does not result in any severe cognitive deficits, but long-term or heavy use may produce subtle impairments in higher cognitive functions such as memory, attention, and the organization and integration of complex information

(Solowij, 1998; Solowij *et al.*, 2002). While subtle, these impairments can affect day-to-day functioning. The longer and more frequently that cannabis has been used, the more pronounced are the cognitive impairments. Some long-term heavy users may complain of memory- or concentration-related problems. Others may not be aware of any cognitive impairment. The therapist should be aware that these subtle cognitive impairments, particularly attentional dysfunction, are not always accessible to the user's conscious awareness. Difficulty in maintaining focus and high levels of distractibility may affect the therapeutic process and developments that should occur between sessions. Impaired memory function may result in forgetting information that was covered in previous sessions. Presenting information in a clear fashion and repeating material across sessions may obviate some of the difficulties clients can run into when trying to integrate the therapeutic process while they are still using (Lundqvist, 1995). It is recommended that more in depth expressive techniques proceed only after the user has quit or reduced considerably for a few weeks.

Typical Sequencing of Treatment Components

Treatment can be either time limited (with a set termination date) or unlimited. The typical recommendation is for 4–6 months (16–24 sessions) of treatment. Brief treatments may also be suitable, depending on the severity of the client's problems and the availability of interpersonal support aside from drug-using companions. Following an assessment in which the clients' drug use and other psychosocial strengths and problems are reviewed, a plan for treatment should be presented. This plan should focus on client-identified goals, and be structured around assessable milestones. Before commencing therapy, it is helpful to conduct a "socialization interview," which introduces the client to the ins and outs of psychotherapy. The format for a socialization interview is given in Orne and Wender (1968).

The relationship between the client and therapist is a special one. Goals define and prescribe this relationship, and maintain its focus on the tasks of therapeutic change. A common goal is to alter or cease cannabis use, while other goals may include improving relationships or professional endeavors. Particularly in time-limited therapy, goals (if they are reasonably achievable) modulate the breadth of material that can be covered during the sessions. A client's goals should be elicited with a statement such as, "what are the three main goals that you want to achieve in these sessions?" The overall goal of SE therapy is to integrate these goals with skills of self-understanding and self-control, in order to help the client achieve mastery over their problems. For

purposes of evaluation, it is helpful to have clients rate the severity of their target complaints at the beginning of treatment, so they can be re-evaluated and compared at the completion (Deane & Spicer, 1998).

It is important to pace therapy sessions so that they proceed smoothly and have a natural beginning, middle, and end. The first 10 min should be left empty for the client to express their immediate concerns and recollections with minimal therapist commentary. The next 30 min contain the therapeutic work: the expressive components and the joint search for understanding. The final 10 min should be spent disengaging from the intensity of the material, and should gradually progress towards more general work. A frequent error of inexperienced therapists is interpreting too soon and for too long. In these cases, the client is abruptly cut off when the 50 min are up, and there is no time for reflection or strengthening the therapeutic alliance. Another error of inexperienced therapists occurs when they operate in the supportive mode for the whole session, which can deter progress and exploration.

Based on our treatment-outcome experience, a sample 16-week treatment would proceed as follows. Following the assessment and socialization interview, the first session should involve eliciting goals and establishing therapeutic arrangements (e.g., discussing the time limit). Sessions 2–4 should focus on inaugurating and nurturing a strong therapeutic alliance in preparation for the client's upcoming task of reducing or ceasing cannabis use. It is recommended that the client have a trial abstinence from cannabis before setting a quit date. The 4th session of therapy is generally a good time period to coincide with the client's quit date. Also in the 4th session, the major features of the client's interpersonal functioning and the role of cannabis within their life are assessed to derive a preliminary CCRT formulation. Sessions 5–6 involve monitoring the client's withdrawal from cannabis, using mainly supportive techniques. Sessions 7–12 typically focus on the client's core problems and CCRT patterns, and use mainly expressive techniques. Sessions 13–16 continue the exploration of interpersonal issues, but introduce preparation for termination as an increasing priority. Reinforcing mastery and its preventive role in averting relapse becomes helpful in the final phase of treatment.

Therapist Training

Any qualified mental health practitioners such as social workers, psychologists, or psychiatrists, can be trained to use this approach. In order to adequately deliver this psychotherapy, the trainee should meet the following three criteria. First, the trainee should have a general orientation to the dynamic psychotherapy

approach, as based on psychoanalytic tradition (e.g., Gabbard, 1990). Second, the trainee should be conversant with the specific SE dynamic techniques (Barber & Crits-Christoph, 1995; Book, 1998; Grenyer *et al.*, 1995; Luborsky, 1984). Third, the trainee should receive individual clinical supervision of their casework by an experienced practitioner. In addition, if possible, audio recordings of the trainee's psychotherapy sessions should be checked for treatment fidelity using an adherence scale (Luborsky, 1984).

Studies of SE Psychotherapy with Cannabis Users

As reviewed above, there are a number of treatment-outcome trials that have evaluated the utility of SE psychotherapy for drug dependence. With regards to cannabis, only one outcome trial to date has been conducted using this approach. A brief overview of this study is presented here. In addition, further work has been done on investigating additional processes in the application of SE therapy for cannabis dependence and this work is also reviewed below.

The aim of the outcome study was to compare a 16-session time-limited version of SE dynamic therapy for cannabis dependence with a brief self-help intervention (Grenyer *et al.*, 1996a), following a successful pilot study (Solowij *et al.*, 1995). Participants ($n = 100$, 79 males, mean age 32.7 years, SD 7.7, range 20–56) with a primary DSM-IV diagnosis of cannabis dependence were recruited through local media and treatment agencies. Participants were required to have used cannabis for at least 5 years, and to have used daily or nearly daily use within the past 30 days. Participants were excluded if they had other drug abuse or dependence. Following confirmation of entry criteria, participants were assigned to groups of 50 using an adaptive or quasi-randomization procedure (Pocock, 1975). As individuals were recruited, their duration of cannabis use was monitored and balanced between groups since cognitive impairments which might impact on treatment have been shown to develop with increasing years of cannabis use (Solowij, 1998; Solowij *et al.*, 2002). There were no differences between groups on intake drug use or clinical variables.

The psychotherapy group received 16 sessions of manual-driven SE dynamic psychotherapy. Adherence to the protocol was monitored through weekly supervision sessions, and independently verified for adherence and competence using a random subset of therapy audiotapes. Participants in the brief self-help group received a single session of brief advice and self-help materials, including a self-help guide to quitting (Grenyer *et al.*, 1996b). This guide contained sections on health information about cannabis, and instructed readers on topics such as: how to assess the pros and cons for quitting (e.g., health, financial, social, and

legal issues); how to make a contract to quit; how to deal with withdrawal symptoms; how to cope with lapses and maintain change; and finally, the guide addressed situations that might reinforce drug use. After discussing the participants' history of cannabis use and their current problems, the clinician provided brief motivational advice to reinforce the participants' personal choice in quitting, oriented them to the use of the self-help guide, and then discharged them from treatment. Participants in the SE psychotherapy group also received a copy of the self-help guide to quitting, but this material was not incorporated within therapy. Seven trained dynamic psychotherapists (5 female, mean age 40.1 years, range 29–48) conducted the SE psychotherapy, and two trained graduate psychologists (2 females, aged 26 and 27 years) conducted the brief intervention. The primary outcome variables were: (1) reported abstinence from cannabis and recent frequency and quantity of use; (2) severity of psychiatric symptoms measured by the Global Assessment of Functioning Scale (GAF – Axis V of DSM-IV; American Psychiatric Association, 1994) and the Beck depression inventory (BDI; Beck *et al.*, 1961); and (3) consumer outcome and satisfaction ratings.

Results found that the whole sample achieved significant reductions in cannabis use at 4 and 12 months. At the 4-month follow-up, a significant difference between the groups emerged in terms of self-reported abstinence – 58% of the psychotherapy participants were abstinent compared to 16% of the brief intervention participants (Chi-square = 18.92, $p < 0.001$). Urinalyses were available for 41% of the sample that self-reported abstinence at 4 months, and confirmed abstinence in 93% of cases. By the 12-month follow-up, the difference between the two groups in terms of self-reported abstinence was no longer significant: 28% of psychotherapy participants were abstinent compared to 14% of the brief intervention participants (Chi-square: 2.95, $p = 0.09$). Analyses of quantity and frequency of cannabis use showed essentially the same results, with a significant difference favoring the psychotherapy group at 4 months, but a non-significant trend by 12 months. With respect to improvements in psychiatric symptoms, both groups improved significantly in the first 4 months of treatment on both the GAF and BDI, but there were no additional gains from 4 to 12 months. The psychotherapy group improved significantly more compared to the brief group at 4 months and this superiority was maintained at 12-month follow-up. Consumer outcome and satisfaction ratings significantly favored the psychotherapy group compared to the brief self-help group, with participants in the psychotherapy group rating being more satisfied (78.6% versus 63.5%, respectively), and more likely to recommend the treatment to a friend (90.2% versus 65.9%).

To summarize, the SE psychotherapy was more effective than the brief self-help intervention over the 4-month treatment study period in achieving abstinence, reductions in cannabis use and improvements in mood and general psychiatric functioning. Participants in the psychotherapy group were more satisfied with the treatment received. By the 12-month follow-up, both groups had significant reductions in cannabis use with a non-significant trend favoring the psychotherapy group. The psychotherapy group also maintained superior gains in general psychiatric functioning and reductions in symptoms. While the results of the study support the notion that psychotherapy leads to better outcomes than self-help treatment, what remains unclear is whether these results can be explained by particular features of the SE technique, or more non-specific effects such as the cumulative effect of attention from a trained counselor. In addition, the therapists conducting the brief intervention were slightly younger and had different training experience than the dynamic psychotherapists, which may also have contributed to differences in outcomes. To further investigate these questions, a process study was conducted to examine the relationship between clinical gains and changes brought about by the SE techniques.

The process study explored the mode of action of SE psychotherapy, and helped to articulate how its application could assist the long-term habitual user. This study investigated changes in a clinically relevant concept: the client's mastery (self-understanding and self-control), scored from the verbatim transcripts of interviews at the beginning of treatment and at the 4-month follow-up of 43 long-term cannabis users (Grenyer, 2002b). The participants were a representative subsample of the 100 from the outcome study (23 in the psychotherapy group, 20 from the brief intervention group). Each participant was asked to speak for 5 min about "your life at the moment – the good things and the bad – what it is like for you" following the instructions by Viney (1983). Although the instructions specify 5 min (as a guide), many spoke for longer than 5 min. The verbatim transcripts were then scored using the Mastery Scale (Grenyer, 1994), which involves content analysis of clausal speech by assigning mastery scale scores to scorable clauses. The Mastery Scale is a reliable and valid research instrument (Grenyer & Luborsky, 1996), and has six levels: (1) lack of impulse control (e.g., being overwhelmed, extreme defensiveness, regression, and ego-boundary ruptures); (2) introjection and projection of negative affects (e.g., paranoia, sadistic and rageful feelings, helplessness, and interpersonal withdrawal); (3) difficulties in understanding and control (e.g., cognitive confusion, ambivalence, partial awareness, and struggling with change); (4) interpersonal awareness (e.g., questioning the self and others' points of view, and interpersonal assertion); (5) self-understanding (e.g., having insight into repeating

personality patterns of the self and others in the present and past); and (6) self-control (e.g., being able to analyze emotional conflicts and show emotional self-control over them). For each level, the manual specifies 3–4 typical categories of statements indicative of that level, making a total of 23 categories (from A–W) for the whole scale. Statements in client speech that corresponded to one of the 23 types of categories were assigned the corresponding mastery level score independently by two trained judges with high inter-rater reliability. These scores were averaged for each sample (deriving a mastery score between 1 and 6) and used in the analysis.

Initial mastery scores between the two groups were not significantly different ($F = 0.17$, $p = 0.68$), with the psychotherapy group averaging a mastery score of 2.98 (SD 0.92) and the brief self-help group 3.18 (SD 0.71). By the 4-month evaluation, analyses of covariance of mastery scores controlling for initial intake scores significantly favored the psychotherapy group (mean 4.61; SD 0.77 versus 3.13; SD 0.92, respectively, $F = 24.6$, $p < .001$). At 4 months, 87% of the SE group were abstinent, compared with 20% of the brief self-help group. Those who were abstinent had significantly higher mastery scores than those who were not abstinent (mean 4.52; SD 0.76 versus 3.09; SD 1.00, respectively, $F = 28.14$, $p < 0.001$). These data support the view that the SE psychotherapy techniques contributed to augmented mastery, and that these gains were associated with a greater likelihood of abstinence from cannabis.

Figure 10.2 illustrates differential changes in the six mastery levels at the 4-month evaluation, as made by the psychotherapy group in comparison to the brief self-help group. Given that there were few changes in mastery for the brief self-help group, this group's 4-month mastery data was used as a quasi-baseline from which to contrast the changes found in the psychotherapy group. We calculated proportions of scorable clauses (indicative of each level of mastery) from the transcripts for the psychotherapy group, and subtracted the proportions found in the brief self-help group. This yielded a graphic representation that showed the largest increase and the largest decrease in levels of mastery among members of the psychotherapy group, with respect to levels found in the brief self-help group.

The psychotherapy group had reductions in the lower level mastery scores compared to the brief intervention group, as indicated by the negative percent change in levels 1 (lack of impulse control) and 2 (introjection and projection of negative affects) categories. Conversely, there were gains in levels 4–6, which are indicative of higher mastery. In particular, for this sample of cannabis users, SE psychotherapy particularly improved level 4 (interpersonal awareness; 37% gain), and level 6 (self-control; 46% gain). These changes are

Figure 10.2 Percentage of frequency of Mastery Scale levels appearing in transcripts at 4-month follow-up for the SE psychotherapy group, expressed as percentage change from 4 months brief self-help transcripts. *Note:* $N = 43$. Dimensions indicative of poor mastery (levels 1–3) show a reduction or little difference in appearance in narratives in the psychotherapy group compared to the brief intervention group; dimensions indicative of good mastery (levels 4–6) show a corresponding increase in the psychotherapy group compared to the brief intervention group.

consistent with the SE model of therapy, which involves a focus on interpersonal functioning through mastery of the CCRTs, leading to greater self-control over drug use and the interpersonal problems associated with this use. In particular, the participants in this sample evidenced greater self-assertion and greater understanding of their repeating personality traits. This helped them overcome helpless and hopeless feelings associated with their cannabis use, which were evident at the beginning of treatment. Psychotherapy provided an escape from the feeling of being interpersonally trapped and conflicted within their relationships, and lead to a greater sense of self-control.

Illustrative Case Study

The following brief case study illustrates some of the SE psychotherapy processes, and how they and how they lead to positive change. John, aged 47 years and married with three children, had been smoking cannabis continuously since he was 16 years. He came to treatment concerned that his life was stagnating, his relationships were suffering due to his drug use, and cannabis was adversely affecting his memory and ability to complete tasks at work. At intake, his GAF score was 56 and his BDI score was 22, indicating moderate

to severe symptoms and impact on life functioning. He met 5 of the 7 DSM-IV criteria for cannabis dependence. Early measures of therapeutic alliance indicated that he had formed a positive relationship bond with his therapist, who focused on being supportive of John's struggle to change his drug use and overcome his feelings of depression. John's goals were to quit cannabis use, to improve his relationship with his wife, and to improve his functioning at work. He commented that "dope covers up my feelings, my despair inside, it keeps my worries and feelings away and allows me to float off." He reported considerable problems with relating to his partner, which he attributed partly to his tendency to procrastinate, and partly to his explosive feelings of anger. He would typically arrive home from work angry and frustrated, and to counter these feelings, he would sit in front of the television and "smoke dope and withdraw from the world and my worries." This enraged his wife, who constantly complained that his life was going nowhere and that he was not talking to her or helping with the children. He reported feeling trapped in a vicious circle – dope was helping him overcome his feelings of stress in the short term, yet was significantly impacting his ability to achieve at work and maintain personal relationships.

During the early phase, the therapist found it difficult to keep John focused on his goals, as he would frequently divert the conversation to superficial topics. Eventually, the therapist became aware that the client was struggling with intimacy, keeping his wife, relationships with his work colleagues, and keeping his therapist at a safe distance to prevent a deeper relationship from forming. Cannabis was being used to block out intimate relationships and his conflicted emotions. The therapist chose to use an expressive technique to interpret these feelings for the client by stating, "I keep getting this feeling that the relationship you are in is very detached and that there is a sadness about the detachment." The client broke down crying, admitting, "I never talk to anybody about myself, how I feel, because they might take advantage of me. People take advantage of your vulnerabilities." His use of cannabis as a crutch to cope with these feelings was explored. With the therapist's support, John was able to quit cannabis after the first month of treatment and work on his ability to relate to others in the new drug-free state. Over the middle phase of therapy, a number of strikingly similar relationship themes emerged and were further explored. John related being teased at school and being dismissed by his father when approached for help. These and other experiences lead him to bottle up his feelings and withdraw, resulting in having no friends and feeling unable to talk to his parents about his feelings. A strong CCRT pattern had been established – a wish to reach out and communicate with others, and an experience of others responding to him by

taking advantage, ridiculing or dismissing him. John's characteristic response was to withdraw and avoid others in order to feel safe. The therapist helped him become aware of this pattern, and see how it was pervasive in his relationships and tied to the core of his difficulties and goals. At the end of therapy, he stated that "feeling safe with my therapist has really helped me to see beyond what I was feeling and get to the roots of it ... I realize that marijuana was blocking a lot of issues inside me that needed to be discussed, and through therapy I feel I now understand myself more and feel I have grown in my emotional development." His GAF score at follow-up was 71 and his BDI score was 3, indicating mild to minimal symptoms.

Conclusion and Future Directions

SE dynamic psychotherapy offers one potentially useful approach to help cannabis users who want to change their drug use. As interpersonal, social, intimacy, and work difficulties are often reported by cannabis users, this approach may be particularly salient as it focuses not only on drug use, but also on the relationship between use and interpersonal problems. It is useful due to its focus on the meaning of drug use within the context of the client's life. The therapy is structured to allow these holistic links to be formed and understood. It is respectful of the client because it allows them to freely discuss their current goals, concerns, and difficulties, and takes these as the primary material upon which to work within the sessions. Previous studies with other drugs of abuse have compared SE psychotherapy with CBT, and found the two therapies to be of equivalent effectiveness. For cannabis dependence, the evidence to date suggests that in addition to eliciting significant reductions in cannabis use, SE psychotherapy is particularly effective at dealing with comorbid depression, anxiety, and other symptoms.

Future research needs to further investigate the application of this approach to different client populations, such as adolescent cannabis users or those with more pronounced polysubstance abuse. Further clinical trials are needed to compare it to another standard treatment delivered over an equal number of sessions. To date, evidence in the psychotherapy field suggests that longer treatment leads to better outcomes. Some evidence proposing that the optimum cost-benefit occurs at approximately 26 weeks of treatment (Howard *et al.*, 1986). It remains to be seen whether better outcomes may be achieved for cannabis dependence by extending therapy duration. Community validation studies are required to assess its utility within community clinics, and it would be valuable to assess the utility of an SE group therapy format with cannabis users.

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