Relapse Prevention in Chronic Marijuana Smokers

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Despite an increasing volume of research on marijuana during the past decade, the treatment literature on adult, chronic abusers of marijuana remains limited. The primary focus of research and theory in both the clinical and psychosocial literature has largely been on adolescent and young adult marijuana use, reflecting a general emphasis on prevention. In a monograph entitled *Treating the Marijuana Dependent Person* [3], published by the American Council of Marijuana, only one out of 15 papers was concerned with treatment of an adult population.

The absence of a relevant literature, however, does not reflect the absence of a population of chronic marijuana abusers and the need for effective intervention programs. Recent estimates in the United States indicate that more than 20,000 people are in treatment for dependency on marijuana [3]. This figure may be an underestimate as marijuana abuse can be embedded in multiple substance abuse patterns [2].

Although the thrust of recent psychosocial research has been on identifying the characteristics of youthful users of marijuana, findings from some of this research can provide direction for new efforts targeted at treating adult abusive users of marijuana.

These include findings that:

1. Social learning factors such as the social interaction environment play an important role in the continuing use of marijuana [5].
2. Individuals report using marijuana to cope with negative affective states such as feelings of frustration and failure [9].
3. In research on factors associated with cessation of marijuana use, continuing users were found to be more lacking in a stable identity than ex-users and those who had never used the drug [8].

Investigators involved in this area acknowledge the need for more research on the characteristics of marijuana abusers, on factors associated with the cessation of marijuana use, and on the transition from moderate to abusive use patterns [5, 9].

Addictive Behaviors: A Social Learning Perspective

The social learning perspective [1] defines addictive behaviors as overlearned maladaptive habit patterns [7]. Focus is placed on understanding both the determinants and the consequences of addictive behaviors. Included as determinant factors are: environmental or situational antecedents, beliefs and expectations, and prior history or experience with a given substance. Consequences of addictive behaviors in-
clude positive and negative physical sensations, personal payoffs (e.g., the use of a substance as a means of coping with life stress), and social reactions.

Many cognitive-behavioral strategies have evolved from the social learning perspective. These strategies have been applied, individually and in combination, to the treatment of addictive behaviors such as alcoholism, cigarette smoking, overeating/obesity, and drug addiction. Specific therapeutic strategies include covert sensitization, thought-stopping, counter-conditioning, reinforcement, cognitive restructuring, coping skills training, self-instruction, and skills in problem solving.

One recent focus of theory and research has been on the problem of relapse, a matter of considerable importance due to the frequently reported failure of treatment to result in long-term maintenance of therapeutic changes [4, 6]. Having studied the factors associated with relapse across a range of addictive behaviors (e.g., heroin addiction, alcoholism, smoking, gambling, and overeating), Marlatt and Gordon [6] have developed a cognitive-behavioral model of the relapse process.

An individual who has attained both control over the once out-of-control behavioral pattern and a commitment to maintain that control, may be at risk of relapse when confronted with specific high-risk situations. Most commonly associated with an initial instance of “backsliding” once control has been attained are unpleasant or negative emotional states such as frustration, anger, anxiety, or boredom. A second commonly reported relapse situation is the occurrence of interpersonal conflict. Additionally, the experience of social pressure is often a factor in triggering a relapse episode. In the clinical studies surveyed by Marlatt and Gordon [6], more than 70% of relapses were associated with one of the three preceding types of risk factor.

The cognitive-behavioral model of relapse postulates that an individual who has an effective coping response in order to deal with situations posing high relapse risk will experience both an increased sense of self-efficacy and a decreased probability of subsequent relapse. The individual who does not have an adequate coping response, however, may have both a decreased sense of self-efficacy and an anticipation that engaging in the addictive behavior, e.g., having a drink or getting stoned, will lead to a positive resolution of the problematic high relapse risk situation. If this person then slips and uses the substances, he or she is likely to experience guilt and a sense of personal failure, both of which are capable of fueling subsequent relapse episodes.

This model suggests the application of a number of intervention strategies. The relapse prevention therapeutic model to be described below encompasses two sets of intervention procedures:

1. Cognitive processes (e.g., decision-making strategies for increasing one’s motivation and commitment to change an addictive behavior such as compulsive marijuana smoking and the identification of cognitive chains that may provide early warning signals that a relapse is imminent).

2. Behavioral skill training (e.g., learning to cope with high-risk situations that may trigger a relapse, and learning to develop alternative life-style behaviors to reduce the temptation to resume abusive marijuana use).

In a 2-year period (1981–1983), 41 adults who were chronically smoking marijuana and sought counseling were treated by the first author. The therapy involved ap-