



Efficacy of a targeted cognitive–behavioral treatment program for cannabis use disorders (CANDIS*)

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Abstract

Aims: To examine the efficacy, 3- and 6-month follow-up effects of a psychological treatment for older adolescents and adults with DSM-IV cannabis use disorders. The program was tailored to the needs of this patient population. **Experimental procedures:** A randomized controlled clinical trial of 122 patients aged 16 to 44 years with DSM-IV cannabis dependence as the main substance use diagnosis was conducted. Patients were randomly assigned to either Active Treatment (AT, $n=90$) or a Delayed Treatment Control group (DTC, $n=32$). Treatment consisted of 10 sessions of therapy, detailed in a strictly enforced manual. Assessments were conducted at baseline, during each therapy session, at post treatment and at follow-up assessments at 3 and 6 months. **Results:** The treatment retention rate was 88%. Abstinence was achieved in 49% of AT patients and in 13% of those in DTC ($p<0.001$; intend-to-treat (ITT) analysis). Further, AT patients improved significantly ($p\leq 0.001$) in the frequency of cannabis use per week, addiction severity, number of disability days, and overall level of psychopathology. Program effects were maintained over a 3-month- (abstinence rate: 51%) and 6-month follow-up (45%) period. **Conclusion:** The treatment program is effective in obtaining abstinence as well as reducing cannabis use and improves the associated social and mental health burden.
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1. Introduction

Cannabis use (CU) has been in the center of the drug debate since rates of use increased in Anglo-American and EU countries during the 1990s. Cannabis is the most commonly used illicit drug worldwide, particularly among young people (UNODC, 2010). Up to 50% of all adolescents and young adults

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in Europe and in Germany have consumed cannabis at least once (European Monitoring Center for Drugs and Drug Addiction, 2007). Prospective-longitudinal examinations document that among lifetime users about 60% become regular users and 12% will eventually develop cannabis use disorders (CUD) (Nocon et al., 2006; Perkonig et al., 2004, 2008; Wittchen et al., 2008a). Transitions from first use to regular use and CUD typically occur within the first few years (Behrendt et al., 2009; Wittchen et al., 2008a). Regular use and especially CUD are associated with an increased probability of psychosocial and mental health problems, mental disorders (Fergusson and Horwood, 1997; Hall and Solowij, 1998; Henquet et al., 2005; Iversen, 2005; Lundqvist, 2005; Perkonig et al., 2008; Wittchen et al., 2007, 2009), and increased help seeking behavior (Nocon et al., 2006). The etiological mechanisms and pathways of CUD development and the emergence of a cannabis dependence syndrome remain unclear, although a substantial body of research highlights a wide range of specific vulnerability and risk factors (Behrendt et al., 2009; DeWit et al., 2000; Fergusson et al., 2003; Höfler et al., 1999; van den Bree and Pickworth, 2005).

Among CUD subjects without any other illegal substance use, a substantial unmet treatment need exists (Wittchen et al., 2009). In fact, European reports (European Monitoring Center for Drugs and Drug Addiction, 2007) indicate that CUD-patients have become the largest group in substance use services among all illegal drug users in many EU-countries. This report further highlighted that effective interventions for this particular group are lacking and understudied. Epidemiological studies reveal that a substantial proportion of subjects with heavy CU or CUD utilize and abuse cannabis as the only or dominant substance (Perkonig et al., 2006; Wittchen et al., 2009). The number of such patients has been increasing in almost all countries (European Monitoring Center for Drugs and Drug Addiction, 2007). There is also epidemiological evidence (Perkonig et al., 2006) that despite seeking help, only a small fraction of subjects with CUD receive professional help, suggesting a considerable degree of unmet needs in this group.

According to a recent review (Denis et al., 2009), few studies have examined the effectiveness of treatments for CUD-patients. Nevertheless, there is restricted evidence from randomized clinical trials – all based on US or Australian samples – with encouraging results (Copeland and Swift, 2009; Denis et al., 2009; Zimmermann et al., 2004) for poly-pragmatic brief cognitive-behavioral therapy (CBT). These studies mainly targeted adults and some include minimally impaired individuals with cannabis problems (McRae et al., 2003; The Marijuana Treatment Project Research Group, 2004). Effective treatment components include standard CBT- and motivational enhancement techniques (MET), skills training and relapse prevention elements. It is noteworthy that psychoeducation is almost never specified as part of the intervention and comorbid mental disorders are not targeted. Concerns about the generalizability of existing interventions exist because interventions developed for US and Australian care system may not transfer to other systems (Hoch et al., 2007a,b). Structure, content and procedural aspects of the existing programs and approaches have raised concerns about their appropriateness with regard to substance use patterns, age of patients, patients' problem profiles in European countries and about the programs' efficacy in routine care

(Hoch et al., 2007a,b). These concerns about the degree to which extant therapies match the needs of patients and treatment providers in European systems may have impeded their wider use and dissemination (Simon and Sonntag, 2004). These concerns refer to differences in use patterns, and in the US, Australian and German CU populations. For example, epidemiological data suggest that the main incidence phases of CU, CUD, and associated psychosocial problems are primarily in adolescence and early adulthood (Behrendt et al., 2009; Georgiades and Boyle, 2007; Monshouwer et al., 2005; Perkonig et al., 2008; von Sydow et al., 2002; Wittchen et al., 2009; Wittchen et al., 2007). Consistent with this, patients with CUD, present for treatment typically at younger ages (mean age: 24 years) in the German outpatient drug treatment system (Pfeiffer-Gerschel et al., 2010). The average age in existing trials is typically higher (e.g., MRT-trial: mean age 36.1 years (Stephens et al., 2002)). There are also differences in socio-demographic variables, such as higher rates of men and unemployed subjects in Germany. Importantly, abstinence (and not CU reduction as in the US and Australian studies (The Marijuana Treatment Project Research Group, 2004)) is the primary goal of substance use treatment employed by German psychotherapy health care providers.

Based on substantive prospective – longitudinal epidemiological investigations in the community to describe the problems and needs of the CUD target population (Höfler et al., 1999; Perkonig et al., 1999; von Sydow et al., 2001; 2002), we developed a multistage targeted treatment program for CUD patients, with tests of its efficacy and subsequent transfer of research results into routine care (For a more detailed description of the study and the design see Hoch et al., 2011a). Based on our needs assessment, we adapted modules from the few existing treatment programs with empirical validation (Budney et al., 2000; Copeland, 2004; Copeland et al., 2001; Denis et al., 2006; Litt et al., 2008; McRae et al., 2003; Stephens et al., 1994, 2000, 2002; The Marijuana Treatment Project Research Group, 2004; Zimmermann et al., 2004), to fit the German population. The adapted content, structure and procedures resulted in the targeted "CANDIS" (CANNabis DISorders) treatment manual. As high-incidence phases for CU and CUD and the highest 12-month prevalence rates for CUD are found from late adolescence to early adulthood (Compton et al., 2004; Wittchen et al., 2008b) the CANDIS program matches the problems and needs of adolescents (age ≥ 16 years) and adults with problematic CU.

This paper (1) describes the CANDIS treatment and (2) presents findings of a randomized controlled clinical trial. Patients were randomly allocated to either the Active Treatment (AT=CANDIS) consisting of a standardized cognitive-behavioral treatment package or a control group condition, in which patients waited for 3–4 months before beginning treatment (Delayed Treatment Condition, DTC). We hypothesized that (a) the active treatment (AT) would lead to better treatment outcomes than the DTC condition with regard to increased abstinence rates, reduced CU, improvement in addiction severity, disability days and general psychopathology and (b) treatment effects would remain stable over the 3- and 6-month follow-up period.

The program was originally tested in two versions, a *Standardised Treatment* (ST) and a more individualized *Targeted Standardized Treatment* (TST). The two treatment conditions did not differ significantly in any outcome (results

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