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A Running Start

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The subtitle of this chapter—a running start—conveys a very important aspect of guided self-management treatment. Since not much time is spent with a client, the treatment is designed to cover a great deal of material quickly and efficiently. Thus, the assessment not only gathers data but also provides the start of an accelerated treatment process.

Entering Self-Management Treatment

First, and foremost, it is important to determine that the client will accept a self-management treatment approach. In our case, since the treatment provided was one of many services offered, clients were screened at a central intake. When a new client was identified as eligible for the self-management program, the intake worker explained that the treatment was being evaluated and that if the client participated in the treatment, he or she would be part of a research study. The client was then provided with a written description of the treatment, which follows in an abbreviated form:

> *About Guided Self-Management Treatment*
>
> Guided self-management is a treatment program developed specifically for certain types of persons with alcohol problems; namely, persons who do not have severe alcohol problems. The treatment program emphasizes helping persons recognize and use their own strengths to resolve their drinking problems. It involves a comprehensive assessment, which gathers information about the person's drinking problem and factors that might be important to take into account in order to understand the problem. After the assessment, clients read two short booklets describing the treatment approach, complete two homework assignments relevant to their treatment, and attend two 90-minute outpatient treatment sessions. Following this, clients can receive additional treatment at their request.

A brief written description was used so clients would understand from the start that the treatment

would involve their taking major responsibility for formulating and enacting their own treatment plan. The role of the therapist and of the program materials is to provide guidance to help clients accomplish these tasks, but the focus is on helping people help themselves. These points can be communicated by a therapist just as easily as by written description. What is important is that clients understand what they are getting into before they make the commitment.

Describing self-management as an approach designed for people who want to take responsibility for helping themselves and whose problems are not very severe is a motivational strategy intended to reinforce clients' self-confidence that they can succeed in conquering their drinking problem. It is considered important in brief treatments to provide clients with a sense of optimism (Zweben, Pearlman, & Li, 1988).

Finally, we recommend that all clients be alcohol free when clinically assessed. This recommendation derives from a large body of research conducted by ourselves and others on the validity of alcohol abusers' self-reports of drinking and drinking-related information. In general, it has been found that alcohol abusers' self-reports are reasonably accurate if clients are interviewed when alcohol free, are seen in a clinical or research setting, and are given assurances that the information they provide will be confidential (Babor, Stephens, & Marlatt, 1987; O'Farrell & Maisto, 1987; L. C. Sobell & M. B. Sobell, 1986, 1990; Sobell, Sobell, & Nirenberg, 1988). The latter condition is part and parcel of all clinical treatment (Rankin, 1990).

In addition, there is evidence that if clients are not alcohol free when interviewed, their self-reports of drinking are not reliable. In a study of new admissions to an outpatient treatment program, we found that in 50% of the cases in which a client had a positive blood alcohol level, the client's self-report of drinking was discrepant with the breath-test reading (Sobell, Sobell, & VanderSpek, 1979). In nearly all cases with a positive blood alcohol level (92 out of 93), the client substantially underreported how much he or she had drunk prior to the interview.

To determine that clients are alcohol free, we recommend breath testing. Numerous inexpensive breath testers are available for use in offices (e.g., M. B. Sobell & L. C. Sobell, 1975). While such devices are screening rather than evidential testers (i.e., they are not legally binding), they are sufficiently accurate

for clinical use, are quick and easy to administer, and require no special training. Breath testing is a relatively unobtrusive way of determining whether clients have alcohol in their system. In our experience, it has been extremely rare for a client to object to the test. If the test indicates more than a negligible blood alcohol concentration, we recommend that the client be instructed that it is necessary to be alcohol free for the assessment and that the assessment be rescheduled.

In our opinion, breath testing communicates to the client a professional approach to the treatment of alcohol problems. People are familiar with the use of tests when health problems are being assessed (e.g., urine tests for glucose levels), or treated (e.g., hypertension), and alcohol problems are no different. It is good clinical practice, especially at the assessment, to test whether the client is alcohol free rather than taking the client's word for it.

One might expect that the clinical opinion of experienced staff is all that is needed to identify clients who have been drinking, and thus that breath tests for blood alcohol level are unnecessary. The above study (Sobell et al., 1979) also addressed this point. Experienced clinicians first recorded their own judgment about whether the client had been drinking, then recorded the client's self-report of recent drinking, and finally breath tested the client. These experienced clinicians failed to identify 50% of the clients who gave self-reports that were discrepant with their breath test.

The above results illustrate the phenomenon of tolerance. Tolerance is an adaptation in the individual that occurs as a result of drinking, especially frequent drinking. This adaptation can be thought of in two ways. First, with repeated drinking experiences, it takes an increasing amount of alcohol to achieve the same response in an individual that previously was produced by a smaller dose. The alternative way to conceptualize tolerance, and a way that may have relevance for explaining why some people come to increase their consumption over time, is that it takes a greater amount of alcohol than in the past to achieve the same degree of effect. Thus, a person who previously felt "intoxicated" after consuming three or four drinks might with repeated drinking experiences find that he or she needs to consume six or seven drinks to feel the same way. Acquired tolerance to alcohol helps explain why even trained clinicians are not good judges of a person's blood alcohol level, especially if they have not had much prior experience with the client in a sober state. A person with high acquired tolerance may have a substantial blood alcohol level yet not display obvious drunken behavior.

Assessment as a Therapeutic Process

The assessment information that clients provide their therapists yields a picture of the client's drinking and related problems. Clinicians with little experience with problem drinkers may be surprised that the assessment process sometimes constitutes the first time that clients have given any intensive thought to their drinking and related problems. When considered in context this becomes understandable. While problem drinkers sometimes drink to excess, on many other occasions they drink without problems or the risk of problems. Often when they seek treatment their alcohol problems do not dominate their lives, and sometimes the problems are even perceived as a nuisance rather than as a major threat to their well-being (Thom, 1986, 1987). For problem drinkers who have not spent much time thinking about their drinking patterns, and whose drinking has not seriously disrupted their lives, just completing an assessment interview can be an illuminating and, it is hoped, motivating experience.

At the end of the assessment clients in guided self-management treatment are given Reading 1, which provides a framework they can use to organize their thoughts and the assessment information that they have reported. They are also given Homework Assignment 1, which asks them to perform a functional analysis of their drinking. These two features of the treatment constitute the main components of getting a running start. A few points are pertinent at this time.

First, Reading 1 provides an overview of the cognitive-behavioral self management approach that forms the basis for treatment. While most clients who have gotten this far accept the approach and find it consistent with their view of their problems and of what they need to do, there will be some clients who cannot accept the approach or who on reflection feel that it does not really fit their case. In such cases, clients should be reassessed and offered appropriate alternatives. Thus, the first reading can also serve a screening function.

Second, Reading 1 and Homework Assignment 1 prepare the client to perform a functional analysis of their own drinking. The reading describes the basic components of a functional analysis of drinking, and Homework Assignment 1 requires that clients perform such an analysis on their own drinking. Thus, the reading and assignment enable the client to integrate the information covered during the assessment and to organize it in a meaningful manner. This helps to give them an early start on their treatment. Prior to starting the first treatment session, they have a basic knowledge and understanding of the treatment

approach that will be taken, and they have formulated major portions of a functional analysis of their own drinking. As a result, clients enter formal treatment prepared to go ahead at full speed.

The assessment also serves to prepare the therapist for dealing with the client. If the assessment is conducted by someone other than the therapist, we recommend that the therapist be provided with a clinical summary of the assessment, known as a "Clinical Assessment Summary," and be given the assessment materials in advance of the first treatment session. A sample of a completed Clinical Assessment Summary appears as Figure 6.1. Even when the therapist performs the assessment, a Clinical Assessment Summary can be useful because it provides a concise, readily available reference about important aspects of the case. Furthermore, since most therapists have a large caseload, the Clinical Assessment Summary facilitates recall of important aspects of a given case, and it avoids having to review all the assessment material. The time needed to prepare a Clinical Assessment Summary of the type shown here is minimal.

Name: _____ Date Completed: _____

CLINICAL ASSESSMENT SUMMARY

ADS Score: 9 ADS Components: Hangovers; acute effects; tried unsuccessfully to cut down.

Age: 41 Sex: (M) F Yrs. Education: 18 Marital Status: (M/C) NM S D W

Employment Status: Full-time Occupation: Truck dispatcher

No. of Alcohol- or Drug-related Arrests: 0 No. of Jobs lost due to Alcohol or Drug use in past year.: 0

Ever purposely abstinent: (Y) N Longest no. mos. purposely abstinent: 2 Family History of Alc. Problems: (Y) N

Prior A/D treatment: Y (N) Describe: _____

Problem Self-Appraisal: Major problem. Spouse threatens to leave if he doesn't bring his drinking under control.

Alcohol Consequences: Blackouts; interpersonal conflict; late for work.

Other Drug Use: Nil

No. of Yrs. problem drinking: 4 No. of Yrs. heavy drinking: 7 No. days morning drinking in past yr.: 1

Timeline		
Past 360 days	172 No.. of days Abstinent	72 No. of days 5 – 9 SDs
	81 No. of days 1 – 4 SDs	35 No. of days ≥ 10 SDs

Drinking (Patterns, features, or use characteristics): Weekdays drinks lightly or not at all. Many weekends (Fri., Sat., Sun.) drinks about 8-12 drinks on a day, sometimes 15. With friends at a bar, whiskey. Cut down recently to 1 day/week.

☐ **IDS** (heavy use situations in past yr.): Elevations on positive affect scale suggest a good times drinker. A bit of control testing.

☐ **SCQ** (vulnerability): Perceives major vulnerability when control testing. Somewhat vulnerable when feeling good.

Goal: 3 drinks on 5 times per week; 1 time a month as many as 5 drinks. Always in the presence of spouse and with her approval.

Additional Observations: Spouse has already been helping him to cut down.

In summary, assessment as conducted in guided self-management treatment is more than a data-collection procedure: Assessment is the start of treatment. Clients are informed about the basic principles of the treatment and are given the task, following the assessment session, of beginning to functionally analyze their drinking. They come to the first treatment session familiar with the orientation of the treatment and with materials to talk about. Likewise, the therapist entering the first session is familiar with the case and ready to begin the treatment. This "running start" for the client is an integral part of guided self-management treatment as a motivational intervention, and it is a procedure that is not typical of other brief treatments.

Selected Assessment Tools and Procedures

The assessment recommended here has the central features of any good clinical assessment of an alcohol problem (e.g., gather information on sociodemographic factors, drinking-problem history and drinking patterns, consequences of drinking, other substance use) as well as some added features. Various ways of gathering basic sociodemographic information are not discussed here, nor are assessment instruments that only serve research purposes. Instead, the focus is on instruments and procedures that we have found to have exceptional clinical utility.

Screening Procedures

Since the self-management approach discussed in this book is intended for and has only been evaluated with persons who are not severely dependent on alcohol, one needs some way of identifying such clients. A combination of procedures can be used for this purpose: (1) clients' scores on a self-report measure of dependence; (2) their report of never having experienced severe withdrawal symptoms; and (3) a medical assessment to verify those reports. The medical assessment that we have used primarily for research studies is usually unnecessary in clinical practice.

For assessing dependence, we recommend using the Alcohol Dependence Scale (ADS) (Skinner & Allen, 1982; Skinner & Horn, 1984). The ADS is a well-validated instrument for which a user's manual and normative data are available. While the ADS is one of several scales (Davidson, 1987; Sobell, Sobell, & Nirenberg, 1988) developed to measure the alcohol dependence syndrome (Edwards & Gross, 1976),

some of the available instruments have been criticized for not actually measuring that construct (Davidson, 1987; Edwards, 1986). For the present purposes, the issue of whether such scales truly tap all dimensions of the hypothesized dependence syndrome is secondary to how well they identify problem drinkers.

While most of the available dependence scales are relatively sensitive for differentiating among levels of severe dependence (e.g., Severity of Dependence Questionnaire) (Stockwell, Murphy, & Hodgson, 1983), very few are sensitive at lower levels of dependence (Davidson, 1987). The ADS, however, is able to differentiate among persons with lower levels of dependence (Skinner & Allen, 1982). An alternative instrument sensitive to lower levels of dependence is the Short Alcohol Dependence Data (SADD) questionnaire (Davidson & Raistrick, 1986). The ADS and the SADD are relatively comparable; the major difference is that since the SADD is not copyrighted it can be reproduced at no charge. Both scales are quick to administer (ADS = 25 items; SADD =15 items), and both have satisfactory psychometric characteristics.

A conservative cut-off criterion on the ADS is a score of 21 or less (the 50th percentile on norms constructed at the Addiction Research Foundation, Toronto). Persons scoring below the 50th percentile on the ADS rarely have experienced severe withdrawal symptoms (i.e., seizures, hallucinations, delirium tremens) (Skinner & Horn, 1984). The ADS also has individual items about severe withdrawal symptoms that can be double checked to insure that none of the items were answered positively by the client.

In our studies, we have also briefly screened for evidence of probable organic brain syndrome using two standardized tests: (1) the Trail Making Test, using age adjusted scores (Davies, 1968) and (2) the Digit Symbol and Vocabulary subscales on the Wechsler Adult Intelligence Scale (Wilkinson & Carlen, 1981). Since certain parts of the intervention involve reading materials, we have also screened clients for their reading ability using the Wide Range Achievement Test (Jastak & Jastak, 1965). However, unless there is a question about brain damage or reading ability, clinicians can assess their clients without such tests. The major concern is to exclude clients who have low levels of literacy or for whom there is evidence of impaired cognitive function, especially impaired abstracting abilities. These kinds of exclusion factors are applicable to conducting any type of cognitive treatment with alcohol abusers.

Finally, for research purposes we have often excluded clients who are frequent heavy drinkers. In one study, for example, clients were excluded who reported that over the past 6 months they had consumed an average of at least 12 standard drinks on at least 5 days per week. This criterion was based on a pilot study in which other screening criteria had failed to identify some extremely heavy drinkers, and for whom a low-intensity, self-managed treatment did not seem a good treatment choice. Based on clinical experience, it is our recommendation that very heavy drinkers should not participate in self-management treatment, unless the number of sessions and length of time in treatment are increased. While some of the principles of self-management treatment might have applicability for more serious cases, such applications should be prudent.

Measuring Drinking: The Timeline Follow-Back Method

The assessment of drinking is a critical feature of any treatment for alcohol problems. Clinically, it is helpful to have a complete picture of the drinking. However, the assessment procedure should not be unduly burdensome. To gather drinking data, we have used the Timeline Follow-Back method.

The Timeline Follow-Back technique was developed a little over 20 years ago as a research follow-up data procedure to provide information on posttreatment drinking (L. C. Sobell & M. B. Sobell, 1973, 1992b; Sobell, Sobell, Leo, & Cancilla, 1988). It was an alternative to procedures popular at that time, such as classifying individuals as either drinking or abstinent, with no further information on the amount or pattern of drinking.

Another popular procedure at the time was the quantity-frequency (QF) method, whereby people estimate on average how many days per week they drink, and how much they typically drink on a drinking day. QF' procedures have limited utility for assessment or follow-up in clinical populations (Room, 1990; L. C. Sobell & M. B. Sobell, 1992b) because they force people to impose a pattern on their report of their drinking, when their drinking might actually be quite unpatterned. Also, days of heavy drinking, if in the minority, tend to go unreported in QF estimates (i.e., they are not part of the "average" or "typical" pattern). The Timeline Follow-Back procedure avoids these problems by asking people to recall as well as possible all of their drinking that occurred during a specified interval.

The Timeline method asks people to reconstruct their drinking on a day-by-day basis over a particular interval using a blank calendar. Readers unfamiliar with this technique might think that clients are not able to reconstruct their drinking over an extended period of time. However, a sizable body of research shows this can be done with reasonable reliability (i.e., reports of the same interval tend to be stable over time) and validity (i.e., reports of significant others agree well with those of the clients; official records verify instances of alcohol-related consequences. (See Babor et al., 1987, L. C. Sobell & M. B. Sobell, 1992b, and Sobell, Sobell, Riley, 1988, for reviews of this research.)

The Timeline method is a retrospective procedure and as such requires people to provide best-recall estimates of their past drinking. If a client reports having consumed 14 standard drinks on January 17th, when it may have been 16 or 12 drinks, and it may have been on the 15th or the 18th, this degree of reporting error is no greater and probably less than that incurred by other methods. The important point is that the Timeline will provide a reasonably accurate summary of the major features of the drinking: amount, frequency, pattern, and degree of variability.

In order to understand the richness of Timeline data for clinical purposes, it is important to know something about the instructions people are given regarding how to reconstruct their drinking. Clients completing a Timeline calendar are told that what is most important is that they reconstruct their drinking as well as they can. They are told that it is not expected that their report for long intervals will be absolutely accurate, but that it should be as close to what really occurred as possible. Clients understand that the purpose of the procedure is to provide the therapist with a visual summary of their drinking over the reporting period.

In research studies, the pretreatment Timeline typically covers the 12 months prior to the interview. In clinical practice, however, the interval can be shortened to 90 days prior to treatment, particularly if the client reports that that interval is representative of the pretreatment pattern. Clients are asked to record their drinking on the calendar, thereby providing a picture of what their drinking was like, including patterns of drinking (e.g., heavy weekend drinking) and any changes in the pattern over time (e.g., switched from mostly heavy weekend drinking to drinking almost daily for the month prior to entering treatment). Clients are also asked to record the amount of alcohol they consumed in standard drink units (a standard drink contains a specified amount of ethanol irrespective of the type of

alcoholic beverage, see Chapter 7). If the client reports that the 90 days prior to entering treatment are not representative of a longer pretreatment interval (e.g., 1 year), then the client can complete a second calendar reflecting a "typical" 90-day period or can be asked to indicate in what ways the 90-days period just preceding treatment was atypical.

Since providing Timeline data is often perceived by clients as a formidable task, they are also apprised of several aids that may help ease the task of reconstructing their drinking. One important memory aid is to have clients identify the dates of significant events during the reporting period. These may be generic events (e.g., New Year's Day, major sporting event, major news event) or idiosyncratic events (e.g., their own or others' birthdays, dates of important personal events such as changing jobs, dates of vacations or personal holidays). It is helpful to write these events on the Timeline calendar. Clients will often remember what they were doing around these "anchor" dates and can use them to reconstruct their drinking for substantial periods. Calendar aids have also been used to help clients recall alcohol-relapse episodes (McKay, O'Farrell, Maisto, Connors, & Funder, 1989), drug use (Adams & Henley, 1977), and other events (Gorman & Peters, 1990).

Another aid to constructing a Timeline is to have clients recall lengthy periods of time when they completely abstained, drank in a very patterned manner (e.g., 6 drinks every day; 2 to 4 drinks per day on Monday through Thursday and 10 to 12 drinks Friday through Sunday), or drank heavily for an extended time period. Other techniques can be used to target in on approximate levels of consumption in difficult cases. For example, if a client reports having drank "a lot" of beers on a day but claims an inability to specify what "a lot" means, "bracketing" can be helpful. The client can be asked "does 'a lot' mean 24 beers or 6 beers?" A typical response to this question by the client might be "certainly not 24 beers, more like 12 or so." If desired, one can target in further by asking "was it 12 beers or could it have been more like 9 or 15 beers?" For research studies, the probing continues until the specification is as precise as possible. For clinical purposes, however, the important questions usually involve how frequently clients drink, the pattern of drinking, and how often they consume large amounts and small amounts when they drink. Thus, it makes little practical difference if a large amount is 12 drinks or 15 drinks or if a small amount is 2 drinks or 3 drinks, as long as the major features of the drinking are captured.

The clinical value of the timeline goes beyond simply providing drinking data, however. Studying

the completed Timeline, the therapist and the client can readily gain a picture of the main features of the drinking during the period in question. For example, did drinking increase over the pretreatment period? Was there a distinct pattern to the drinking? Did the drinking bear obvious relationships to possible antecedents (e.g., holidays, recreational activities, paydays, weekends)? Figures 6.2, 6.3, and 6.4 provide examples of Timelines taken from actual cases, illustrating how a completed Timeline can provide a clinically useful summary of clients' drinking.

360-day Timeline

Subject No.: ____

Today's Date: June 10 Start Date: June 15 End Date: June 9

	SUN	MON	TUES	WED	THURS	FRI	SAT
JUN	1	2	3	4	5	6	7
	8	9	10	11	12	13	14
	15 Father's Day 2	16 2	17 0	18 3	19 0	20 10	21 7
	22 0	23 3	24 10	25 0	26 3	27 7	28 7
	29 2	30 8	1 Canada Day 4	2 3	3 3	4 10	5 7
JUL	6 0	7 3	8 10	9 0	10 3	11 7	12 7
	13 2	14 0	15 3	16 0	17 3	18 10	19 7
	20 DAD BDAY 6	21 6	22 10	23 2	24 10	25 10	26 10
	27 2	28 0	29 0	30 2	31 0	1 10	2 7
AUG	3 8	4 Civic Holiday 4	5 10	6 0	7 3	8 7	9 7
	10 2	11 0	12 3	13 0	14 3	15 10	16 7
	17 0	18 3	19 10	20 0	21 3	22 7	23 7
	24 2	25 0	26 3	27 0	28 3	29 10	30 7
	31 8	1 Labour Day 2	2 10	3 0	4 3	5 7	6 7
SEP	7 0	8 3	9 10	10 0	11 3	12 10	13 7
	14 0	15 3	16 10	17 0	18 3	19 7	20 7
	21 2	22 0	23 3	24 0	25 3	26 10	27 7
	28 0	29 3	30 10	1 0	2 3	3 7	4 7
OCT	5 2	6 2	7 0	8 0	9 3	10 10	11 Birthday 10
	12 7	13 Thanksgiving 3	14 10	15 0	16 3	17 7	18 7
	19 2	20 0	21 3	22 0	23 3	24 10	25 7
	26 0	27 3	28 10	29 0	30 3	31 Halloween 7	1 7
NOV	2 2	3 10	4 3	5 10	6 3	7 12	8 10
	9 0	10 10	11 Remembrance 3	12 10	13 3	14 10	15 10
	16 2	17 0	18 3	19 0	20 3	21 10	22 7
	23 0	24 3	25 10	26 0	27 3	28 7	29 7
	30 2						

	SUN	MON	TUES	WED	THURS	FRI	SAT
		1 0	2 3	3 10	4 0	5 10	6 7
DEC	7 0	8 3	9 10	10 0	11 3	12 7	13 7
	14 2	15 0	16 3	17 0	18 3	19 10	20 7
	21 0	22 3	23 10	24 5	25 Christmas 6	26 7	27 7
	28 2	29 0	30 3	31 12			
					1 New Year's Day 2	2 10	3 7
JAN	4 0	5 3	6 10	7 0	8 3	9 7	10 7
	11 Plan Week 2	12 0	13 3	14 0	15 3	16 10	17 7
	18 2	19 1	20 10	21 5	22 9	23 12	24 3
	25 10	26 1	27 2	28 2	29 2	30 10	31 7
FEB	1 0	2 3	3 10	4 0	5 3	6 7	7 7
	8 2	9 0	10 3	11 0	12 3	13 10	14 Valentine's Day 7
	15 0	16 3	17 10	18 0	19 3	20 7	21 7
	22 2	23 0	24 3	25 0	26 3	27 10	28 7
MAR	1 0	2 3	3 10	4 0	5 3	6 7	7 7
	8 2	9 8	10 3	11 5	12 5	13 10	14 7
	15 0	16 6	17 12	18 3	19 0	20 10	21 10
	22 2	23 10	24 3	25 10	26 14	27 10	28 12
	29 8	30 3	31 15	1 0	2 0	3 0	4 6
APR	5 0	6 3	7 0	8 3	9 0	10 5	11 6
	12 0	13 3	14 0	15 3	16 0	17 Good Friday 7	18 8
	19 Easter Sunday 2	20 Easter Monday 3	21 3	22 0	23 3	24 8	25 6
	26 0	27 2	28 3	29 0	30 3	1 7	2 7
MAY	3 2	4 0	5 3	6 0	7 3	8 10	9 7
	10 Mother's Day 2	11 3	12 10	13 0	14 3	15 10	16 8
	17 8	18 Victoria Day 2	19 0	20 3	21 3	22 10	23 7
	24 2	25 2	26 10	27 0	28 3	29 7	30 7
	31 0	1 9	2 7	3 0	4 3	5 11	6 7
JUN	7 0	8 9	9 0	10	11	12	13
	14	15	16	17	18	19	20
	21 Father's Day	22	23	24	25	26	27
	28	29	30				

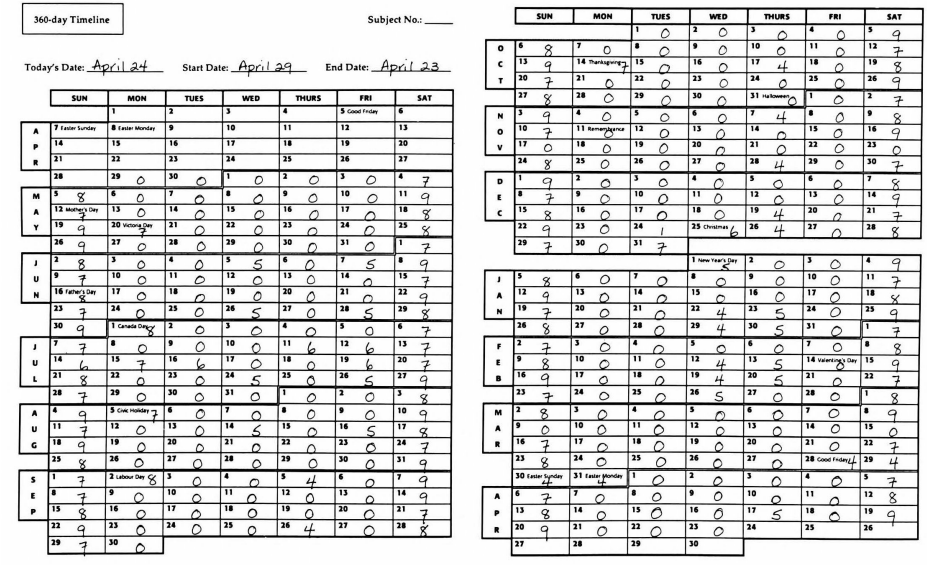
360-day Timeline

Subject No.: ____

Today's Date: Nov. 26 Start Date: Dec. 1 End Date: Nov. 25

	SUN	MON	TUES	WED	THURS	FRI	SAT
		1 0	2 0	3 5	4 5	5 3	6 20
D	7 0	8 0	9 0	10 5	11 3	12 20	13 2
E	14 2	15 0	16 0	17 5	18 2	19 4	20 20
C	21 5	22 0	23 0	24 5	25 Christmas 3	26 20	27 0
	28 0	29 0	30 0	31 20			
					1 New Year's Day 3	2 3	3 20
J	4 0	5 0	6 0	7 5	8 3	9 20	10 2
A	11 2	12 0	13 0	14 5	15 2	16 0	17 20
N	18 5	19 0	20 0	21 5	22 0	23 20	24 0
	25 0	26 0	27 0	28 5	29 5	30 4	31 20
F	1 2	2 0	3 0	4 5	5 3	6 20	7 2
E	8 5	9 0	10 0	11 5	12 2	13 3	14 Valentine's Day 20
B	15 0	16 0	17 0	18 5	19 0	20 20	21 0
	22 2	23 0	24 0	25 5	26 5	27 0	28 20
M	1 5	2 0	3 0	4 5	5 3	6 20	7 2
A	8 0	9 0	10 0	11 5	12 2	13 20	14 0
R	15 2	16 0	17 0	18 5	19 0	20 4	21 20
	22 5	23 0	24 0	25 5	26 5	27 20	28 0
	29 0	30 0	31 0	1 5	2 2	3 3	4 20
A	5 0	6 0	7 0	8 5	9 0	10 20	11 0
P	12 2	13 0	14 0	15 5	16 3	17 Good Friday 4	18 20
R	19 Easter Sunday 0	20 Easter Monday 0	21 0	22 5	23 0	24 20	25 2
	26 2	27 0	28 0	29 5	30 2	1 3	2 20
M	3 0	4 0	5 0	6 5	7 0	8 20	9 0
A	10 Mother's Day 3	11 0	12 0	13 5	14 3	15 4	16 20
Y	17 0	18 Victory Day 0	19 0	20 5	21 0	22 20	23 2
	24 2	25 0	26 0	27 5	28 5	29 3	30 20
	31 5						

	SUN	MON	TUES	WED	THURS	FRI	SAT
		1 0	2 0	3 5	4 2	5 20	6 0
J	7 5	8 0	9 0	10 5	11 0	12 4	13 20
U	14 5	15 0	16 0	17 5	18 3	19 20	20 2
N	21 Father's Day 5	22 0	23 0	24 5	25 0	26 3	27 20
	28 5	29 0	30 0	1 Canada Day 5	2 5	3 20	4 0
J	5 5	6 0	7 0	8 5	9 0	10 4	11 20
U	12 5	13 0	14 0	15 5	16 2	17 20	18 2
L	19 5	20 0	21 0	22 5	23 3	24 3	25 20
	26 5	27 0	28 0	29 5	30 0	31 20	1 0
A	2 5	3 Civic Holiday 0	4 0	5 5	6 5	7 4	8 20
U	9 5	10 0	11 0	12 5	13 0	14 20	15 2
G	16 5	17 0	18 0	19 5	20 2	21 3	22 20
	23 5	24 0	25 0	26 5	27 3	28 20	29 0
	30 2	31 0	1 0	2 5	3 0	4 4	5 20
S	6 0	7 Labour Day 0	8 0	9 5	10 5	11 20	12 2
E	13 2	14 0	15 0	16 5	17 0	18 3	19 20
P	20 0	21 0	22 0	23 5	24 2	25 30	26 0
	27 2	28 0	29 0	30 5	1 3	2 4	3 20
O	4 0	5 0	6 0	7 5	8 0	9 20	10 2
C	11 2	12 Thanksgiving 0	13 0	14 5	15 5	16 3	17 20
T	18 0	19 0	20 0	21 5	22 0	23 20	24 0
	25 2	26 0	27 0	28 5	29 2	30 4	31 Halloween 20
N	1 0	2 0	3 0	4 5	5 0	6 20	7 2
O	8 5	9 0	10 0	11 Remembrance Day 5	12 3	13 3	14 20
V	15 2	16 0	17 0	18 5	19 2	20 20	21 0
	22 5	23 0	24 0	25 5	26	27	28
	29	30	1	2	3	4	5
D	6	7	8	9	10	11	12
E	13	14	15	16	17	18	19
C	20	21	22	23	24	25 Christmas	26
	27	28	29	30	31		



A computer-administered software program of the Timeline Follow-Back method is currently being developed, and a preliminary version of the program has been field-tested. The computer program contains instructions for completing the calendar; it provides users with a country-specific standard drink conversion menu (e.g., for the United States, Canada, Great Britain, Australia); it facilitates recall by listing major events and holidays on the calendar; and it also allows users to list personal holidays and events. The computer version has some advantages over a paper-and-pencil method. Most notably, the drinking data can be automatically analyzed and graphed, and immediate feedback can be provided to the user. A recent publication describing the Timeline method in considerable detail provides some samples of the types of data that can be generated by the computerized version of the Timeline (L. C. Sobell & M. B. Sobell, 1992b).

Assessing High-Risk Drinking Situation

Another instrument originally developed for research purposes that we have found very useful for treatment planning is the Inventory of Drinking Situations (IDS) (Annis, Graham, & Davis, 1987). Based

on self-efficacy theory (Bandura, 1977) and on reports of the importance of situational factors in relapse (Marlatt, 1978; Marlatt & Gordon, 1985), Annis formulated a 100-item questionnaire assessing situations in which a person drank heavily over the year prior to being interviewed. Although a 42-item version of the IDS is now available (Annis et al., 1987), we have used the 100-item instrument in our research, and we feel that this version has the greatest clinical utility. Annis et al. (1987) also have recommend using the 100-item version for clinical purposes.

The items on the IDS represent eight categories of potential high-risk situations for drinking, based on a classification system developed by Marlatt and his colleagues (Marlatt & Gordon, 1985). The eight categories form subscales that combine to form two major classes of situations, Personal States "in which drinking involves a response to an event that is primarily psychological or physical in nature" (Annis et al., 1987, p. 1) and Situations Involving Other People where "a significant influence of another individual is involved" (Annis et al., 1987, p. 1). Clients are asked to respond to each item with regard to how often they "drank heavily " in that situation, using a 4-point scale ranging from 1 = Never to 4 = Almost Always.

One problem with the IDS is that the determination of heavy drinking is left to the client's discretion, and there is no provision on the questionnaire for gathering information about the client's subjective definition of heavy drinking. Since knowing how a client defines heavy drinking can be essential for evaluating the client's responses, it is recommended that an additional question be routinely appended to the form asking: "By 'heavy drinking' I mean drinking at least standard drinks in any particular situation."

The classes and subscales, along with one sample item for each subscale of the IDS follow:

Personal States

Unpleasant Emotions (When I felt that I had let myself down)

Physical Discomfort (When I felt nauseous)

Pleasant Emotions (When I felt satisfied with something I had done)

Testing Personal Control (When I started to think that just one drink could cause no harm)

Urges and Temptations (When I suddenly had an urge to drink)

Situations Involving Other People

Conflict with Others (When other people treated me unfairly)

Social Pressure to Drink (When I was in a restaurant and the people with me ordered drinks)

Pleasant Times with Others (When I wanted to celebrate with a friend)

The psychometric characteristics of the IDS are satisfactory and are described in the User's Guide for the instrument (Annis et al., 1987). Others have also validated the IDS (Cannon, Leeka, Patterson, & Baker, 1990; Isenhart, 1991). The recommended scoring method is to convert answers into Problem Index scores which range from 0 to 100. This can be done by hand or by computer. A personal computer version of the IDS that includes automatic scoring and a computer-generated client report is available (Annis et al., 1987). The Problem Index scores for the subscales can be used to create a profile for clients describing the types of situations most associated with their heavy drinking over the year prior to the interview. Case examples including IDS profiles are presented in Chapter 11.

When interpreting clients' answers to the IDS, it should be noted that the situations covered by the questionnaire derive from Marlatt's (Marlatt & Gordon, 1985) research on alcohol abusers' reports of situations associated with their initial relapse to substance use following treatment. The assessments made for the IDS, however, involve clients' reports of how often they "drank heavily" in particular situations over the past year. Conceptually, it may be that situations that trigger an initial relapse differ from those regularly associated with heavy drinking. For example, for someone attempting to be abstinent, interpersonal conflict might be the situation most likely to result in a return to drinking, although drinking with friends may be the situation where most of the person's heavy drinking has occurred. At the present time, we are not aware of any studies disentangling these two aspects of drinking situations.

For problem drinkers, we find the IDS (which identifies situations associated with heavy drinking) to have more face validity and clinical utility than an approach asking clients about relapse precipitants. This could be because the drinking of problem drinkers is largely inconsistent with a relapse prevention

model. The problem drinkers we have studied do not describe their drinking as involving extended periods of abstinence interrupted by "relapses" where initial drinking leads to continued heavy drinking. With regard to the initiation of drinking, when problem drinkers drank they frequently did not drink heavily (they reported drinking four or fewer drinks on nearly 40% of their pretreatment drinking occasions). The majority of our clients reported that on the day following a day of heavy drinking they either did not drink or drank substantially smaller amounts.

Another reason we recommend the IDS is that we found high concordance between the scale scores and the types of situations that clients identified in their homework assignments as most problematic (see Chapter 9). However we do not recommend substituting one for the other: The IDS provides a broad generic picture of the clients' heavy drinking situations, whereas the homework answers provide a detailed evaluation of a few of the client's most serious problem situations.

An important feature of the drinking of the problem drinkers we have studied that was identified both in their IDS and in their homework answers was the frequently reported relationship between positive affect and heavy drinking, a finding that parallels data collected by others using the IDS (Annis, Graham, & Davis, 1987; Cannon, Leeka, Patterson, & Baker, 1990; Isenhart, 1991). This finding has important implications for appetitive motivational theory (Baker, Morse, & Sherman, 1987; Stewart, DeWitt, & Eikelboom, 1984), which postulates that both positive and negative affective states can set the occasion for drug use. It also has implications for the conduct of treatment. This will be discussed further in Chapter 11, when we consider treatment procedures and case examples from the guided self-management approach.

Assessing Self-Efficacy

A parallel instrument to the IDS, which measures self-efficacy, is the Situational Confidence Questionnaire (SCQ) (Annis & Graham, 1988). The SCQ contains the same 100 items as the IDS, but asks persons to indicate on a 6-point scale (ranging from 0 to 100, inclusive, in steps of 20) how confident they feel at the time they complete the scale that they could resist the urge to drink heavily in that situation. The SCQ is intended to measure clients' feelings of self-efficacy in the same situations covered by the IDS. In our experience, most clients' answers to the SCQ parallel their responses to the IDS, and

thus the clinical value of the SCQ for treatment planning is questionable. Occasionally, however, clients report high self-efficacy for a high-risk situation and vice versa. Thus, if the SCQ is not used, it is important to at least ask clients how confident they are that they can refrain from heavy drinking in the situations identified on the IDS as previously associated with their heavy drinking.

Treatment Goal Assessment

We asked all clients to complete a Goal Statement on several occasions, including assessment. A copy of the Goal Statement appears in Chapter 7, where its contents and use are discussed. The Goal Statement is first administered at assessment in order to learn what expectations the client has brought to treatment. For example, if at assessment a client indicates an intention to seek to reduce his or her drinking, but the desired drinking levels are clearly hazardous, this gives the therapist forewarning of an important area for discussion.

Guided self-management is a program of treatment that begins at assessment. The first attempt at integration of assessment materials starts when the client, after reading Reading 1, completes Homework Assignment 1 and brings it to the first treatment session. This facilitates a natural flow from assessment into the treatment sessions.