Treatment Procedures:

Preparation, Goal Setting, Monitoring Drinking

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The Need for Flexibility

While guided self-management treatment has several components, there is no hard-and-fast prescription for ordering or combining the procedures. Practitioners are strongly encouraged to adapt the procedures to their own style and to each particular case. Thus, the order in which the component treatment processes occur can be tailored to each client. For this reason, in the following discussion the treatment procedures are not presented in the context of a strict session outline. Although session outlines are provided later in this book, they are only guidelines for how the therapeutic process might be structured. Finally, in a nonintensive program, it is important that the treatment sessions be well focused and efficient.

In clinical settings where standardization is not needed, the criterion that makes the most sense for determining the length of treatment is how the client responds. For some people a positive response might be evident after a few sessions; for others it may take several sessions. There is nothing inherently wrong with extending the number of treatment contacts beyond that for which the approach was developed, as long as it is kept in mind that the approach was designed as a short-term intervention. Once the procedures have been completed and if progress has not occurred, then it is necessary to evaluate barriers to change and to assess whether this type of treatment should be continued. Questions that can be asked include: Is a self-management approach appropriate for this client? Do the client's life circumstances weigh against change occurring, and if so, can those circumstances be modified to support change? From the client's perspective, is there insufficient motivation for change (i.e., the costs of reducing or stopping drinking are seen as higher than the benefits that would result), and if so, is there any chance that this situation will soon change?

Preparing for Treatment Sessions: The Client's Obligations

Prior to the first treatment session, clients should be informed about certain conditions applying to

the treatment. Typically, these can be discussed at the end of assessment as a therapeutic contract specifying obligations for the client (therapist obligations are presented in the next section):

- Clients should be instructed to be alcohol free when they arrive for sessions. They should know that a breath test can be conducted to verify their status, and they should know that if they arrive for a session with a positive blood alcohol level the session will be rescheduled. This procedure also sets the tone for honesty in the relationship between client and therapist. As mentioned in Chapter 6 and discussed later in this chapter, the availability of an objective test of blood alcohol level is important because of the phenomenon of tolerance; even experienced therapists are not reliably able to identify whether alcohol abusers have a positive blood alcohol level (Sobell, Sobell, & VanderSpek, 1979).

- Clients need to understand the importance of completing the readings and homework assignments prior to the sessions and of bringing them to the session. They should understand that what makes the treatment a "program" is the continuity of procedures from assessment through aftercare. Reading 1, given to clients at the end of assessment, is intended to help them integrate the information that has been discussed during assessment. The Homework Assignment 1 is intended to capitalize on the assessment experience by helping clients become aware of and define their high-risk drinking situations. These procedures build on the momentum generated by the assessment process. Likewise, Reading 2 and Homework Assignment 2 build on the first session. If clients fail to do the readings and homework exercises, questions about their commitment to change should be raised. Our experience to date suggests that the vast majority of problem drinkers will comply with the procedures.

Preparing for Treatment Sessions: The Therapist's Obligations

It is not just the client who is expected to get a running start in the guided self-management treatment. For treatment sessions to be focused, it is important for the therapist to review the assessment materials prior the first session, determine where additional information is needed, and consider possible treatment directions. Likewise, prior to further sessions, notes and materials from previous sessions should be reviewed. One way to facilitate the review process is for the therapist to use a Clinical Assessment Summary (see Figure 6.1) and to update it with any important information obtained in treatment sessions.

Starting the First Session: Setting the Tone

To insure a common understanding and mutual expectations between the client and therapist, the following introductory comments, taken from the script used in guided self-management treatment training for therapists, should be communicated to the client using the therapist's own words.

- The guided self-management treatment approach is not suitable for all people. The primary characteristic of persons who benefit from short-term treatment is that they are not severely dependent on alcohol. They have varying degrees of life problems related to their drinking, but they do not drink to the point where they become physically dependent on alcohol. If they stop drinking they do not suffer major withdrawal symptoms (e.g., hallucinations, seizures, delirium tremens). They do not drink extremely large amounts, and they do not drink every day.

- Studies have shown that certain types of persons with alcohol problems often benefit as much from short-term treatment as from more intensive treatment.

- Guided self-management is a treatment approach that was developed specifically for people who have the personal strengths and resources to overcome their drinking problem on their own if given some guidance.

- The treatment provides a framework, based on research, within which clients can gain an understanding of their drinking problems and develop strategies for avoiding future drinking problems.

- It is important to remember that this is a program of treatment that, although it includes a small number of formal treatment sessions, begins at assessment and can continue on an "as needed" basis after the formal sessions have been completed.

- For some people, the formal treatment sessions and the associated reading materials and homework assignments will be sufficient, while others will need more help.

Goal Setting

A key part of the guided self-management treatment program is that clients are asked to choose their own drinking treatment goal. As discussed earlier, goal self-selection is a treatment component intended to increase clients' commitment to change. Clients appear to do better when the treatment orientation is consistent with their own beliefs, and problem drinkers are more likely to seek to reduce

their drinking rather than abstain regardless of the advice they receive in treatment.

During guided self-management treatment, clients are provided with recommended guidelines for reduced drinking, and they are strongly advised of any medical contraindications to drinking. In our experience, while few problem drinkers will have medical contraindications to a reduced-drinking goal, an assessment is still recommended. To facilitate obtaining objective assessments of medical contraindications to alcohol consumption, it is helpful for therapists treating problem drinkers with a self-management approach to cultivate a working relationship with physicians who are supportive of such an approach. Physicians who value public health approaches to alcohol problems are likely to find compelling the arguments supporting treatments developed for problem drinkers, including ones that offer a reduced-drinking goal. There are exceptions, however, and these typically involve individuals who hold strong conventional beliefs about alcoholism. Such individuals may adopt the empirically unfounded position that anyone who has any problem with alcohol should never drink again. The likelihood of altering such a belief-based conviction is probably small to nonexistent.

The key question in the medical evaluation is whether there are any existing health problems that would be exacerbated by consumption of limited amounts of alcohol. For example, if the client suffers from certain medical problems (e.g., diabetes, gout), then reduced drinking would not be advisable because even limited drinking could worsen such conditions. The medical evaluation should not consider whether the person can achieve reduced drinking, but rather if any serious health problems would be aggravated if the client engaged in limited drinking.

In research studies, we have assessed goal selection at several different points in the program, including at follow-up. In clinical practice, it is recommended that the client's goal be assessed at assessment, and at the first and last treatment session. Goal specification at assessment helps the therapist form a picture of the client and of reasonable treatment expectations. The goal at assessment reflects the client's immediate (i.e., without advice from the therapist) preference for either a reduced-drinking or abstinence goal, and it provides information about how realistically the client has appraised his or her situation. For example, a client whose goal is to reduce consumption to seven drinks a day on 6 days per week would be deemed to have an unrealistic idea of what constitutes nonhazardous drinking.

The vast majority (about 80%) of clients in the guided self-management treatment studies chose a reduced-drinking goal at assessment. Most set relatively conservative and realistic limits for their desired level of drinking, for example, three drinks on about 3 days per week. Thus, there is no indication that clients would misuse the goal-choice situation to rationalize heavy drinking, although this may occasionally occur. This is one reason that the therapist should provide very explicit information on suggested guidelines if the client chooses a reduced-drinking goal.

There are two reasons why it is very important that a reduced-drinking goal be carefully defined: (1) so the client has specific, well-thought-out rules about drinking limits and the circumstances under which he or she may drink, and (2) so the goal definition does not change over time as a way of rationalizing behavior that does not conform to intentions. For goal specification, it is recommended that a Goal Statement be used, a copy of which appears later in this chapter. After completing this form, clients are given a copy so that they have a record of their commitment.

The first time clients are asked to complete the Goal Statement, the following points should be emphasized:

- It is important for the therapist to know what specific type of change in drinking clients are seeking because this provides a basis for evaluating whether clients' efforts are successful.

- Since people sometimes change their goals, the form is completed on more than one occasion. Clients should notify the therapist whenever there is a goal change.

- Upon administration of subsequent Goal Statements, clients are told that there is no need to change answers from the previous goal. The read ministrations are only intended to give clients an opportunity to change their goal if desired and to allow discussion of the change.

- Although goals are discussed in treatment and advice is provided, clients are told that they ultimately must make the decision about whether to drink, and what the limits should be if they choose to drink. For some people, not drinking at all is the best way to deal with their drinking problems. For others, especially if their problems are not very severe, they may be able to reduce their drinking to a level at which it is unlikely to cause problems.

Alcohol Education

It is appropriate to provide some alcohol education at the time the Goal Statement is discussed. Because some clients will enter treatment better informed than others, the extent of information will vary. The main topics for discussion can include absorption, metabolism, and disposition of alcohol by the body; blood alcohol level; standard drink conversions; and tolerance.

Educational pamphlets can also be used to provide some of this information, as long as the pamphlets are scientifically accurate.

Those who can make a personal computer available to clients may be interested in a new computer program that uses several factors (e.g., body water, gender, age, drinking rate) to predict blood alcohol concentrations (Kapur, 1991). The program can be used to educate therapists and clients about factors influencing blood alcohol concentration. Using this program, clients can explore blood alcohol concentration issues in depth.

In discussing various educational topics with clients, it is helpful to use examples that the client will be able to understand. For example, the analogy of the body as a funnel is a useful way of explaining what happens to alcohol when it enters the body. Without discussing technical details about the metabolism of alcohol, the funnel analogy communicates the point that while a lot of alcohol can be consumed quickly, the rate at which it leaves the body is steady and small, which has implications for blood alcohol levels. Such a discussion leads easily into a discussion of standard drinks.

If an assessment procedure such as the Timeline Follow-Back has been used, standard drink conversions may already have been explained. Most clients can readily understand a standard drink nomenclature and have little difficulty reporting their drinking using standard drinks. Familiarizing clients with a standard drink reporting format is also useful in educating clients about the amounts of ethanol in the different types of standard drinks (e.g., beer vs. wine). While therapists can give some general guidelines to clients for calculating blood alcohol levels (Devgun & Dunbar, 1990), it is important to note that there is large individual variability in blood alcohol levels produced in different individuals by a given dose of alcohol.

A discussion of legal definitions of intoxication (e.g., drunk driving) can follow a discussion of blood alcohol levels and lead to a discussion of tolerance. In most states in the United States the legal limit for drunk driving is 10 mg of ethanol per 100 ml of blood (0.10%). In Canada, the legal limit is 0.08%, while in some European countries the limit is as low as 0.04%. It is important for clients to know how much they can drink before they will be legally drunk. This can be simplified by referring to each 0.01% of ethanol as "1 point"; thus, the level of legally defined intoxication in most states in the United States is 10 points. For example, a male client weighing 200 pounds might be advised that each standard drink consumed is likely to increase his blood alcohol level by 2 points within about 20 minutes of drinking. Although factors such as having food in the stomach can slightly delay absorption, the effect of such factors will for most purposes be negligible. The rate at which an individual's body metabolizes alcohol may also be considered as roughly 2 points per hour. Various combinations of consumption associated with a constant rate of metabolism can then be used to show how metabolic rate (funnel example) will determine an individual's blood alcohol level at any given time.

It is also important that clients understand the phenomenon of tolerance. Recall that tolerance means that with repeated drinking experiences the same dose of alcohol affects an individual less. Thus, to achieve the same effect in terms of feeling intoxicated, more alcohol must be consumed. There are two reasons why the notion of tolerance should be discussed with clients. First, tolerance is somewhat independent from blood alcohol level. As tolerance to alcohol is acquired, the person will feel less intoxicated (and be less impaired on several tests) at the same blood alcohol level. The critical issue is that it is unwise for people to gauge their blood alcohol level by their subjective feelings of intoxication. As tolerance is acquired, what changes is the response to a given dose of alcohol, not the resulting blood alcohol level. The legal definition of being "under the influence," however, is tied to a blood alcohol level criterion. In court, what matters is whether the individual's blood alcohol level was above the criterion value.

Making the Point about Tolerance

> An example of tolerance is reflected in the story of an intoxicated pilot, who flew a Northwest Airlines passenger jet without incident from South Dakota to Minnesota ("Flying and Alcohol," 1990). The flight crew was reported to have been drinking heavily prior to boarding the plane. Although the authorities were notified of this, they were not able to intercept the airplane before it departed. While the crew flew the plane without consequence, upon landing they were required to take a breath test. The pilot was found to be legally

intoxicated with a blood alcohol level of 0.16%. In court, the pilot's lawyer maintained that the pilot was an alcoholic who had acquired considerable tolerance to alcohol, and, therefore, his performance was not impaired despite having a high blood alcohol level. While highly alcohol-tolerant individuals can perform well-practiced tasks with minimal impairment, it is on unfamiliar tasks and on certain cognitively complex tasks (e.g., attending and responding to multiple events such as might occur in a flight emergency) that impairment shows up, even at lower blood alcohol levels. Needless to say, the pilot was convicted. This example demonstrates the phenomenon of tolerance and underscores the importance of linking drunk driving to blood alcohol levels and not to performance.

The second reason why a discussion of tolerance is important relates to goal specification. Clients should understand that if their drinking is strongly motivated by a desire to feel intoxicated, then the phenomenon of tolerance can be expected to place them at high risk if they pursue a reduced-drinking goal. That is, if they are drinking for the effect, then they are likely to find that over time they need to consume more to reach the desire state. A wish to become intoxicated often signals a high-risk situation where drinking should be avoided. It is important for clients to understand that if they choose to have a reduced-drinking goal, their drinking should not be motivated by the purpose of achieving a particular state of intoxication or effect. Drinking for effect is inconsistent with a goal of nonhazardous drinking.

Discussing the Goal Statement with the Client

In discussing the Goal Statement with the client, the emphasis should be on the feasibility and reasonableness of the chosen goal. It is useful to provide clients with a set of general recommendations should they seek to pursue a reduced-drinking goal. The recommendations we have used are as follows:

- Consume no more than three standard drinks on no more than 4 days per week. These limits are based on several studies in the literature (Babor, Kranzler, & Lauerman, 1987; Sanchez-Craig & Israel, 1985). It is important to have abstinent days for two reasons. First, by avoiding daily drinking the habitual components of drinking (i.e., drinking a certain amount every day at a certain time) are minimized. Second, abstinent days help avoid developing excessive tolerance to alcohol (i.e., tolerance reverses somewhat in the absence of drinking).

- Do not drink in high-risk circumstances. It makes no sense to drink if there is substantial risk of a negative outcome.

- Drink at a rate no faster than one standard drink per hour, especially if driving.

- In line with a recommendation by Marlatt and colleagues (Cummings, Gordon, & Marlatt 1980), it is suggested that clients impose a thinking period of 20 minutes between deciding to have a

drink and acting on that decision. Such a procedure helps to counteract impulsive drinking, and it gives clients time to reevaluate the reasons for drinking and perhaps to decide not to drink or continue drinking. During this "timeout," clients should consider the risks involved in the particular situation.

About one out of every four or five problem drinkers in treatment will seek to abstain from drinking. The choice of a nondrinking goal, however, should result from a reasoned decision of the likely costs and benefits of that goal, and it should not be based on the client believing that he or she is physically unable to engage in limited drinking. In other words, clients should choose a nondrinking goal because they feel that there is a serious risk that their drinking could result in health and social problems, and this is a risk they are not prepared to take. The motivation for an abstinence goal should be "I have chosen not to drink because that is the best way for me to avoid future problems." It is important that clients be able to provide sound reasons for being abstinent, reasons that relate to what would be risked by drinking. It is the list of reasons for not drinking that will support the long-term commitment to abstinence. Multiple and clearly understood reasons will provide a more stable foundation for abstinence than a belief that control over drinking is not possible.

The purpose of the discussion of the client's Goal Statement is to assess the strength of the clients' commitment to the goal and to reinforce the goal, not to undermine the goal (unless the evidence suggests it is contraindicated). The emphasis should be on evaluating the feasibility and reasonableness of the goal. In many cases, the rationale for the goal will be apparent from the assessment and from the client's description of adverse consequences in Homework Assignment 1 (see Chapter 9).

A good technique for discussing goals with clients is to ask them a series of questions (Miller & Rollnick, 1991). For example, if the goal is abstinence, one can ask clients to discuss their reasons for refraining from drinking. If the goal is to reduce drinking, then the clients should be asked about proposed limits and guidelines, whether the goal is realistic given their history, and whether it is consistent with the avoidance of high-risk drinking (i.e., there should be no substantial likelihood of immediate or long-term consequences of drinking within the limits specified by the goal). Has the client ever been able to drink at low levels and without problems, especially in the past year (see Chapter 9, Homework Assignment 1)? If not, why does he or she believe that it could be achieved now? One question that is sometimes useful in helping clients decide whether a nonabstinence goal is feasible is to ask them

whether they feel it would be easier to not drink at all or to limit their drinking to only one or two drinks per day. When clients respond that it would be easier to not drink at all, often it is because having just one or two drinks would serve no purpose for them (i.e., their drinking is for the effect and because of tolerance would place them at risk of drinking too much).

Finally, although it is recommended that clients be given the opportunity to change or revise their goal, two caveats accompany this recommendation. First, goals should not be changed while the client is drinking or when a high-risk situation is present or imminent. Second, clients should be very careful about changing the goal to allow more drinking. In all cases, the goal should only be modified after full consideration of the potential consequences of the change.

Filling Out the Goal Statement

The Goal Statement, shown in Appendix 7.1, asks clients to specify their goal for the next 6 months. There is nothing special about 6 months; it simply reflects the intervals over which follow-up data were collected on clients in our studies. Such restrictions do not apply to clinical practice. For clinical settings, it is suggested that the therapist negotiate with the client the length of time over which the goal statement will be binding and enter that information on the form. Such a procedure has the advantage of establishing a future date when progress will be evaluated and the goal renegotiated if necessary.

The first question on the form asks clients whether they seek to abstain or to drink in a limited manner. The next set of questions about specific drinking limits are irrelevant for clients whose goal is abstinence. Clients who choose a reduced-drinking goal, however, are required to specify the exact limits they wish to place on their drinking. The amount of drinking is described in terms of standard drinks. The required specifications include the planned average quantity of drinking, the frequency of drinking, the planned upper limit of consumption, and the maximum frequency of reaching that limit. The inclusion of upper limits on the Goal Statement recognizes that while drinking that deviates from the general limits may occur, it should still be kept within planned limits.

The specification of limits is followed by two open-ended questions that ask clients to specify the situations and circumstances in which they will and will not drink. This communicates to clients that

situational variables (the drinking context and their personal state) influence the risks involved in drinking. The conditions specified by clients can be used in treatment. Examples of the types of conditions specified by clients appear in Chapter 11, where case examples are presented.

Although the last two questions on the form were originally included for research purposes, they also have clinical value. The first question asks clients how important it is for them to achieve their goal. Few of our clients have reported that accomplishing their treatment goal is the "most important" thing in their lives. This suggests that if treatment demands become overwhelming, problem drinkers might drop out of treatment.

The second question is a global self-efficacy rating about curtailing their drinking. While there is controversy in the scientific literature about whether self-efficacy can be a global as well as situational variable (Smith, 1989; Tipton & Worthington, 1984; Wang & RiCharde, 1988), for the present purposes this is not important. This question asks clients how confident they are that they will achieve their goal. Evidence from several self-efficacy studies, many with smokers attempting to quit, suggests that an individual's self-confidence in being successful is an important predictor of outcome. Clinically, both of these questions (importance of achieving goal and confidence in the likelihood of achieving goal) provide a clear picture of the client's motivation.

What happens when clients specify limits or circumstances that are inconsistent with the therapist's advice? First, it is prudent to ask clients to provide information honestly, even if it is not in accord with the therapist's advice. It is better to know that a client does not intend to follow the therapist's advice, than to have them try to please the therapist by listing limits that they have no intention of honoring. Knowing that a client is intending to drink more than recommended is useful information. It indicates that drinking at a particular level or frequency is important enough to the client that he or she is willing to incur the risk of negative consequences in order to engage in that behavior. Although clients should be honest in completing the form, it is also important to call their attention to any inconsistencies between their goal and the therapist's advice and to make clear that they understand that what they are proposing is contrary to advice. It is also important to document such situations in a client's record. Thus, while clients should be informed before acting on their decision, it is their decision to make.

In later treatment sessions, the therapist can compare the clients' drinking with their goal. Failure to meet the goal can serve as the starting point for a discussion of whether the treatment goal should be changed. Adherence to the goal can serve as a basis for reinforcing clients' efforts. Since it is the clients' responsibility to make and enact decisions, when they meet their goals they should view themselves as having constructively changed their own behavior. Conversely, when clients do not meet their goals, they should view themselves as responsible for doing something about that, whether it involves changing the goal or changing the way they go about trying to meet the goal. The therapist is an advisor, but the responsibility is the clients'!

Self-Monitoring

It is helpful for clients to self-monitor their alcohol consumption between contacts, beginning with the assessment, and to bring these records to the sessions. Self-monitoring involves recording one's own behavior. In alcohol treatment this includes alcohol consumption and related behaviors such as urges, settings, moods, and other features of drinking situations.

Self-monitoring of drinking is not a recent innovation. In 1973, we reported using the method for alcohol abusers in outpatient treatment, and we discussed ways in which the procedure assisted the treatment process (L. C. Sobell & M. B. Sobell, 1973). One major benefit of self-monitoring is that it forces clients to be constantly aware of their drinking, thereby providing a safeguard against subjectively distorted perceptions of drinking. Over the years, clients have repeatedly said that despite thinking that they knew how much they drank, keeping a record of their drinking provided them with feedback that they were drinking more than they had thought.

Self-monitoring has much clinical utility: (1) it provides a picture of the client's drinking during treatment; (2) it provides a basis for evaluating whether change in drinking is occurring; and (3) it allows for a discussion of drinking without awkwardness. A client's record of the situations and circumstances in which he or she drank between sessions provides a basis for discussion of those events in treatment. An example of the type of form that can be used for self-monitoring appears in Appendix 7.2.

Unfortunately, while the use of self-monitoring has been reported in several studies (Annis & Davis, 1988a; Hester & Miller, 1990; Toneatto et al., 1991), there has been little evaluation of its therapeutic effectiveness. It is possible that just recording one's own drinking might have a "reactive effect" on the drinker and precipitate behavior change (Nelson & Hayes, 1981). Two studies of reactive effects of self-monitoring have been conducted to date, one with normal drinkers (Sobell, Bogardis, Schuller, Leo, & Sobell, 1989) and one with alcohol abusers (Harris & Miller, 1990). Both studies found that self-monitoring did not have a reactive effect on drinking.

Some clients will refuse to self-monitor even when the logs require little information. When this happens, we recommend that the client reconstruct his or her drinking at the session using the Timeline technique. The Timeline and self-monitoring techniques both provide the same type of data—daily drinking. Since the period between sessions tends to be short, the reconstruction using the Timeline technique does not take very long, and discussion of drinking-related event can usually be conducted at the same time that the data are gathered.

In the next chapter our discussion of treatment procedures continues with consideration of materials clients are asked to read. These readings communicate to clients the conceptual basis of the treatment, and they form the foundation for the client to undertake completing the homework assignments.

APPENDIX 7.1.
Blank Goal Statement Form

On this form describe your goal regarding your use of alcohol over *the next 6 months.* Do you intend to not drink at all, or to drink but only in certain ways and under certain conditions?

Do not feel tied to any earlier Goal Statement that you filled out as part of this program.

What is your goal now? If your goal mentions drinking, describe what you mean in terms of amount of drinking and circumstances when you would drink.

1. For the next 6 months, my goal is (Check either Box A or Box B):

☐ A. Not to drink at all
If you checked this goal, go on to question 2, next page.

☐ B. Only to drink in certain ways
If you checked this goal, then answer the following questions, using the following definition of one standard drink:

One standard drink is equal to:

- 12 oz. of *beer* (5% alcohol)
- 1 1/2 oz. of hard *liquor* or spirits (e.g., whiskey)
- 5 oz. of *table wine* (11-12%)
- 3 oz of *fortified wine* (20%)

i. On the average day when I do drink, I will probably drink about _____ standard drinks during the course of that day.

ii. I plan to drink no more than _____ standard drinks during the course of any single day. That will be my Upper Limit.

iii. Over the course of an average week (7 days), I plan to drink on no more than _____ days. (If you plan to drink on less than one day per week, check here: _____)

iv. Over the course of 1 month (30 days), I plan to drink my Upper Limit of drinks on no more than _____ days. (If you plan to drink to your Upper Limit of drinks less than one time per month, check here: _____)

v. I plan to drink *only* under the following conditions:

_____

vi. I plan *not to drink at all* under the following conditions:

_____

People usually have several things that they would like to change in their lives. Changing their drinking behavior can be one of those things. You have just described your drinking goal for the next 6 months. With regard to that goal, answer the following two questions.

2. At this moment, how important is it that you achieve your stated goal? (How hard are you willing to work, and how much are you willing to do, to achieve your drinking goal?)
   Answer this question by writing a number from 0 to 100 in the designated space below, using the following scale as a guide:

0	25	50	75	100
Not important at all	Less important than most of the other things I would like to achieve	About as important as most of the other things I would like to achieve	More Important than most of the other things I would like to achieve	The most important thing in my life

Write your goal importance rating (from 0 to 100) here: _____

3. In the designated space below, indicate how confident you feel at this moment that you will achieve your stated goal. In other words, what is the probability that you will achieve your goal? Use the following scale as a guide:

0%	50%	100%
Not at all confident I will achieve my goal	50/50 chance I will achieve my goal	Totally confident I will achieve my goal

Write your confidence rating (from 0% to 100%) here: _____%

APPENDIX 7.2.
Blank Daily Alcohol Monitoring Form

Name:_____

Goal:_____

DATE	ABLE TO RESIST PROBLEM DRINKING	NO. OF DRINKS BY BEVERAGE TYPE				TOTAL NO. OF DRINKS	SITUATION (Check all that apply)				THOUGHTS. FEELINGS
Record: Month & day	1=Yes 2=No 3=No urges	Beer	Hard liquor	Table wine	Fortified wine	If no drinking occurred on this day, write "0" here.	Alone	With others	In a private place	In a public place	Indicate any thoughts or feelings (e.g., stress, anger, happiness) you experienced just prior to and after drinking.