A Self-Management Approach to Treating Problem Drinkers:

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Earlier chapters reviewed how problem drinkers have become recognized as a population in need of services and the types of approaches that have been shown to be effective for such individuals. This chapter describes the development of a self-management treatment based on the research literature. Our objective was to develop a treatment approach that would appeal to and be suitable for problem drinkers. Problem drinkers were selected as the target population because (1) few treatments exist for this group; (2) it represents a sizable population; and (3) the limited research conducted to date suggests that self-management approaches might work well with such individuals. The resulting approach called "guided self-management," or "guided self-change," has been evaluated in different settings with positive results (Romach et al., 1991; Sellers et al., 1991; Sobell, Sellers, & Sobell, 1990; M. B. Sobell & L. C. Sobell, 1990; Sobell, Sobell, & Leo, 1990).

While detailed statistical analyses of the findings will be presented in peer-review journal articles, this book provides the findings from a clinical perspective, allowing for the discussion of certain topics (e.g., therapists' and clients' views of the treatment) that are clinically important but do not receive detailed attention in journal articles.

This chapter presents the basic principles of and rationale for the guided self-management treatment. Subsequent chapters present the procedures and related assessment tools, treatment outcome information, and a discussion of therapist and client perceptions of the treatment. Based on these findings, recommendations are offered for how the treatment might be modified and used by clinicians. We want to emphasize that treatment can always be improved, and those who use this approach should not feel constrained by the guidelines presented here. In applying the method, readers should make changes that are consistent with current knowledge.

Development of a Treatment Tailored to Problem Drinkers

Based on the preceding chapters, one can draw several conclusions about the nature of an intervention that would be expected to appeal to and be effective with problem drinkers. Such

conclusions were used to develop the guided self-management approach. In particular, the starting point in developing a treatment tailored to problem drinkers included the following premises:

· Treatment should be outpatient and nonintensive.

· Treatment should be largely a motivational intervention.

· Treatment should offer flexibility of treatment goals.

Nonintensive Treatment

Treatment of problem drinkers can be highly cost effective compared to services typically provided for alcohol problems. For problem drinkers, intensive treatments are usually no more effective than nonintensive outpatient treatments. An important qualification is that the treatment outcome findings that form the basis for this conclusion, as with most research-based conclusions, come from studies that compared groups of clients. Although the averaged group outcomes did not differ, it is possible that some individuals benefited more from one treatment than the other. Thus, from the perspective of an efficient health care system, most treatments for problem drinkers should be nonintensive, although for some clients intensive treatment may be warranted. However, intensive treatment should be the exception rather than the rule.

The evidence that very brief interventions can have positive outcomes for problem drinkers (see Chapters 1 and 4) suggests that the major function of treatment with problem drinkers is motivational—to help these individuals use their own resources to bring about behavior change. A behavioral orientation, as exemplified in cognitive-reappraisal therapy (Sanchez-Craig, 1980), individualized behavior therapy (M. B. Sobell & L. C. Sobell, 1978), behavioral self-control (Miller, 1977; Miller & Taylor, 1980), and other behavioral treatments (e.g., Alden, 1988; Chaney, O'Leary, & Marlatt, 1978; Heather, Robertson, MacPherson, Allsop, & Fulton, 1987), is consistent with a motivational focus. All of these treatments emphasize the functional analysis of drinking and the replacement of excessive drinking by alternative behaviors. Most of these approaches also include skills-training procedures, procedures that appear unnecessary for most problem drinkers. For such individuals, all that may be needed is to learn a general strategy for identifying and responding to risk situations. In this regard, Edwards (1980) has

incisively observed that "the intensity of treatment should be kept to a sensible minimum with emphasis on facilitating the patient's own exploitation of his natural resources, on clarification of his own working methods, with treatment an aid to monitoring rather than its being a massive or escalating intervention" (p. 318, italics in original). This conclusion has also been echoed by Miller and Hester (1980), who asserted that "current research suggests that perhaps minimal interventions, rather than 'total push' efforts, would be the prudent norm for treatment in this area" (p. 98).

Based on the above, the therapeutic value of a short-term treatment might be enhanced by: (1) helping individuals learn how to identify generic situations that pose a risk of problem drinking and to use alternative ways of dealing with those situations; (2) helping individuals recognize their own strengths for dealing with risk situations (i.e., a person might possess the necessary skills but not realize how those skills can be used to avoid drinking excessively); (3) increasing the individual's motivation to avoid problem drinking by identifying and emphasizing the adverse consequences of such drinking; and (4) helping the individual recognize the benefits derived from avoiding problem drinking.

Not all agree, however, that nonintensive interventions should be the treatment of choice for problem drinkers. Heather (1989) examined several complex issues relating to such a conclusion and asserted that if one ignores cost-effectiveness considerations, the evidence is insufficient to dislodge intensive outpatient treatment as a treatment of choice for problem drinkers. Part of Heather's argument, however, was based on the contention that many of the brief-intervention studies used sample sizes too small to show a statistically significant difference between brief and more intensive interventions. A later study by Hall and Heather (1991) tested this notion and found that sample size did not account for the failure to find differences between approaches.

Another problem in evaluating the brief-intervention literature has been the combining studies of highly limited interventions (e.g., Chick, Ritson, Connaughtton, Stewart, & Chick, 1988, used a 5-minute advice session) with interventions that involve a few sessions. In a later paper, Heather (1990) teased apart some of these factors and concluded that brief interventions have a reasonable place in the front lines of a system of care for alcohol problems, provided that additional services are available when necessary. This is a well-justified position since the health care system has limited resources, and a consideration of what strategies are most advantageous for the total population in need of services must

be a guiding principle in service planning. The important point is that brief treatments should be conceptualized as part of a treatment system where alternative strategies are available for persons for whom brief treatments are not effective.

No treatment is effective for everyone. With brief treatment there is a special obligation to identify those clients who are not benefiting and to offer other services to them. Also, building a relapse-prevention and management orientation into the treatment might help clients minimize the effects of problems that recur after treatment. A test of the benefits of doing this was the main objective of the seminal study that tested the effectiveness of the guided self-management treatment.

Motivational Interventions

What accounts for the effectiveness of nonintensive interventions? Consider the extreme case where one session of advice/counseling was as effective as much more intensive treatment. Assuming that both treatments were more effective than no treatment, what accounts for the improvement shown by the single-session group? Since the changes cannot be attributed to any intensive or involved procedure (e.g., skills training), it is obvious that the clients already had the skills required to change their behavior and that the advice/ counseling session probably served to catalyze the clients to bring their skills to bear on the problem.

Miller (1983, 1985, 1986/1987, 1991; Miller, Sovereign, & Krege, 1988), who has written extensively on motivational interventions with alcohol abusers, feels that such interventions are particularly suited for problem drinkers. He has emphasized that motivation is a state (and therefore changeable over time) of commitment directed toward some course of action rather than a personal characteristic of an individual.

In a recent book on motivational interventions, Miller and Rollnick (1991) identified several ways that motivation can be enhanced: giving advice; removing barriers to change; allowing clients as much perceived choice as possible in the treatment process; decreasing the attractiveness of drinking; arranging external contingencies to encourage and support change; providing personalized feedback (e.g., blood serum enzyme levels) about the effects of alcohol and using feedback to reinforce progress in

treatment when appropriate; setting clear and feasible goals; and expressing an active helping attitude. From a therapist's perspective, this latter characteristic is defined as "a therapist being actively and affirmatively interested in your client's change process" (Miller & Rollnick, 1991, p. 27).

An important factor related to enhancing motivation is the therapist's interviewing style or what Miller calls "motivational interviewing" (1983; Miller & Rollnick, 1991). The intent is to minimize resistance by the client and to have the client take responsibility for evaluating his or her own problem and for making a commitment to change. The specific features of motivational interviewing include (1) avoiding labeling; (2) using an inquisitive rather than confrontational style to raise clients' awareness of risks and consequences related to drinking; (3) providing objective feedback to clients in a low key style so as not to elicit resistance; (4) reassuring clients that change is possible; and (5) allowing clients choices in treatment planning and goal setting. This type of interviewing style may describe the way many clinicians interact with their clients. The importance of Miller and his colleague pulling these features together is that they relate them to a large body of psychological literature (such as attribution theory and theories of attitude change) that may suggest other ways to enhance motivation (Miller, 1985; Miller & Rollnick, 1991). Many aspects of the guided self-management treatment approach are motivational.

Selection of Treatment Goals

An interesting aspect of successful interventions with problem drinkers is that they often involve a moderation rather than an abstinence outcome (Heather, 1990; Heather & Robertson, 1983; Hester & Miller, 1990; Hill, 1985; M. B. Sobell & L. C. Sobell, 1986/1987). Curiously, this occurs whether or not moderation is a treatment goal (Polich, Armor, & Braiker, 1981; Sanchez-Craig, Annis, Bornet, & MacDonald, 1984). That problem drinkers gravitate toward moderation outcomes when successful, regardless of the advice received in treatment, suggests that offering an alternative to abstinence may be an essential characteristic of services that hope to attract problem drinkers. In fact, the lack of a relationship between treatment goal recommendations and type of treatment outcome is not restricted to problem drinkers. (For a report of a study involving seriously dependent individuals, see Foy, Nunn, & Rychtarik, 1984.)

Since type of successful outcome (abstinence or moderation) has not been found to be significantly related to therapist assigned goals, this raises the question of whether it might be advantageous to have clients select their own goals. Recently, some studies have offered problem drinkers the opportunity to select their own treatment goals (usually with advice from the therapist) (see M. B. Sobell & L. C. Sobell, 1986/1987). Not only has self-selection of treatment goals been hypothesized to increase a person's commitment (i.e., motivation) to goal achievement, but many problem drinkers would prefer to select their own goals (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992).

From the perspective of motivation for change, the major concern is not with the type of goal a client will pursue, but rather with how that decision is made. In guided self-management treatment, clients are asked to specify their own goal. This is done for two reasons. First, the literature suggests that there is no basis for expecting that assigning goals to clients will effect their behavior. Second, self-selection of goals appears to increase commitment to change (i.e., motivation).

According to Bandura's (1986) cognitive social-learning theory of behavior change, goals represent internal standards used by people to evaluate their own performance. He suggests that when goals are explicit, proximal, and perceived to be attainable, people strive to make their performance match their goals (i.e., having goals increases motivation). Bandura cites psychological research indicating that people perform better when they have been actively involved in the goal selection process than when their goals have been designated by others. He hypothesizes that making commitments "under conditions of perceived choice" (p. 478) serves to encourage people to strive to fulfill their goals. Likewise when goals are imposed by others, people do not necessarily feel obliged to fulfill those goals.

Miller (1986/1987) also considers perceived goal choice as important. Part of his exposition on motivational interventions suggests that clients will be more likely to comply with a treatment procedure when they view themselves as having made the decision to pursue that strategy. He hypothesized that allowing alcohol abusers to self-select their own goal would attract more persons to treatment, reduce attrition from treatment, and enhance the likelihood of successful outcomes.

In another study we conducted, alcohol abusers in outpatient treatment were asked to indicate how they would prefer their treatment goals to be determined. Nearly two thirds stated they would prefer to

select their own goal, while slightly more than a quarter preferred the therapist to assign their goal. Clients who preferred goal assignment by the therapist had significantly more severe problems than clients who preferred to self-select their goal. Nearly two thirds of all clients reported they would be more likely to achieve a goal they had set for themselves, even if they had expressed no opinion about whether they or a therapist should select their goal (M. B. Sobell et al., 1992). This study lends support to the notion that problem drinkers would find goal self-selection to be a reasonable treatment approach, and that such a procedure might increase motivation (i.e., that they would be more likely to strive toward a goal they had set for themselves).

There are several other reasons why a goal self-selection procedure is consistent with a self-management approach to treatment. From a long-term perspective, when people achieve goals they have set for themselves, this should strengthen their self-efficacy and consequently help maintain their behavior change. While a person who achieves a goal specified by the therapist might give credit to the therapist for having set the goal, from the standpoint of self-efficacy theory (Bandura, 1986), it would be preferable for the individual to attribute the accomplishment to himself/herself.

Another important benefit of goal self-selection relates to instances when the goal is not achieved. When the goal has been set by the therapist, there are multiple ways that a client can rationalize failure to achieve the goal (e.g., the goal was too demanding; I didn't want to change just to satisfy my therapist; I didn't have the same goal as my therapist). When the pursuit of a self-established goal fails, the issue of goal appropriateness must be confronted directly because the failure cannot be attributed to someone else. Failure to achieve the goal not only sets the stage for discussion about whether the goal should be changed but also for a discussion of the client's commitment or motivation to change.

Although guided self-management treatment allows clients to select their own goals, if there are medical contraindications to drinking, this should be discussed with clients, and they should be advised to choose a goal of abstinence. Likewise, when there are nonmedical reasons why drinking would constitute too great a risk (e.g., if it would provoke serious marital conflict or job loss), clients should be advised against pursuing a goal of reduced drinking. Goal self-selection and specification, integral features of guided self management treatment, are taken very seriously and conducted in the context of safeguards to prevent the procedure from being misused (e.g., to prevent clients from using goal self-

selection as a justification for continued heavy drinking).

Finally, it is advisable to review the selected goal with the client on more than one occasion. Since most clients will not know what goal is the most appropriate for them at the start of treatment, they should be allowed to change their goal if justified. Treatment is a dynamic process, so some treatment decisions will depend on whether particular strategies have been successful. Over the course of treatment a learning process occurs; what is learned can suggest changes in the treatment plan, including a change in goals.

Cognitive Relapse Prevention in Guided Self-Management Treatment

Several decades ago, Wikler (1948) pointed out that there was an extremely high frequency of relapse among substance abusers after treatment. He suggested that environmental factors associated with drug use that were not present during treatment triggered relapse. At the time he proposed his hypothesis, it did not stimulate much research interest. However, in the Ensuing years research has accrued yielding a picture of treatment outcomes marked by the recurrence of drug problems, including alcohol problems. The majority of outcomes include relapses, particularly within the first 6 months following treatment (Allsop & Saunders, 1989b; Gordis, Dorph, Sepe, & Smith, 1981; Hunt, Barnett, & Branch, 1971; Miller & Hester, 1986a; Polich et al., 1981).

Marlatt and his colleagues (Cummings, Gordon, & Marlatt, 1980; Marlatt, 1980; Marlatt & Gordon, 1985) gathered alcohol and other drug abusers' retrospective reports of the occurrence and precipitants of relapse. They found a high frequency of relapse, and they identified three general types of precipitants, which accounted for 74% of relapse episodes among alcohol abusers: negative emotional states, interpersonal conflict, and social pressure. These same factors have demonstrated remarkable consistency across different types of substance abuse, accounting for 72% of relapses among smokers, heroin addicts, gamblers, and uncontrolled eaters (Cummings et al., 1980).

Research on situations associated with relapse underlies the cognitive-behavioral model of relapse formulated by Marlatt and his associates (Marlatt & Gordon, 1985). That model, advanced as applicable to all addictive behaviors "attempts to describe the individual's reaction to a relapse and to examine the

relationship between the first relapse episode and subsequent use" (Cummings et al., 1980, p. 297). Although the model applies most directly to persons seeking abstinence (in such cases the first instance of substance use can be defined as a relapse), it can be extended to individuals who seek to moderate their drinking. In such cases, a relapse can be defined as any instance when a person's drinking transgresses self-imposed rules (Larimer & Marlatt, 1990). Marlatt's approach to understanding relapse involves a social learning perspective (Bandura, 1977, 1986) that includes operant-conditioning and cognitively mediated learning explanations of behavior in addition to classical conditioning. A distinction is made between changing behavior (the acquisition of change) and the maintenance of behavior change, with relapse conceptualized as a failure to maintain change after treatment.

A social learning model of abusive drinking understands relapse as a response to specific stimuli. Therefore, treatment should focus on the client's learning to identify and cope effectively with such stimuli. The relapse prevention model enlarged the social learning approach to specifically include procedures for dealing with relapse, including procedures for maintaining a commitment to behavior change in spite of a relapse, with an emphasis on cognitive aspects of relapse.

Marlatt's model of the relapse process assumes that certain types of situational antecedents, designated as high-risk situations, set the stage for a relapse to occur. The critical determinant of whether or not a relapse occurs is whether the person recognizes the situation for its inherent risk and exercises an appropriate coping alternative. If an appropriate alternative is exercised, the individual not only avoids relapse but also experiences an increased sense of personal control (i.e., confidence in one's ability to avoid relapse) that makes it less likely that relapse will occur in the future. If the individual does not exercise a coping alternative, three factors combine to greatly increase the likelihood that a relapse will occur: (1) failure to cope; (2) diminished sense of personal control resulting from knowing that one has not attempted to cope with a high-risk situation; and (3) short-term positive outcome expectancies for substance use.

If a relapse (or violation) does occur, a "rule violation effect" is presumed to follow. As first proposed, this was referred to as an "abstinence violation effect" because the relapse prevention model was based on an analysis of relapses by chronic alcoholics who were trying to maintain abstinence. The effect refers to an individual attributing a lapse (i.e., initial violation) to a constitutional failing ("I'm just

the type of person who has no control over their behavior"). Such thinking leads the individual to become self-deprecating and feel helpless. This sets the stage for the lapse to develop into a full-blown relapse. Such an experience is hypothesized to increase the likelihood of future relapses. Thus, in relapse prevention there is an emphasis on avoiding the initial violation and then on preventing relapse once a lapse has occurred.

In practice, the relapse prevention approach has focused on two major areas. The first has been on the prevention of relapse, which involves the functional analysis of drinking to identify high-risk situations and the use of coping-skills training to prepare individuals to deal with high-risk situations by means other than drinking. It has also been suggested that clients should be educated to estimate their own blood alcohol levels and that they should be encouraged to use a minimum 20-minute waiting interval between an initial rule violation and continued drinking (Cummings et al., 1980). This delay provides a person with an opportunity to reevaluate the situation and take actions to preclude further drinking. It also separates the triggering events from continued drinking and allows for the possibility that during the delay interval the strength of the triggering events may decrease, better enabling the client to exercise alternatives to continued drinking. Although an emphasis on functional analysis and coping-skills training is integral to relapse-prevention treatments, these are basic behavioral counseling techniques that were used several years before the term relapse prevention was introduced (e.g., Lovibond & Caddy, 1970; M. B. Sobell & L. C. Sobell, 1973; Sobell, Sobell, & Sheahan, 1976). The major contribution of this part of the relapse prevention model has been to highlight general types of situations associated with relapse, which allowed for the development of treatments that could have applicability across individual cases (e.g., Chaney et al., 1978). For example, the identification of interpersonal conflict situations as high risk for relapse suggests that social skills training could be a useful treatment strategy.

The second major area of focus of the relapse prevention model has been the development of approaches for dealing with relapses once they occur. We will refer to this contribution from the model as approaches to relapse management. It is this aspect of the relapse prevention model that we believe has made a unique contribution to the alcohol treatment field. The model has provided a context for discussing with clients the likelihood that relapses will occur. Previously, many therapists would avoid discussing the possibility of relapse lest clients misinterpret such discussion as reflecting a lack of confidence in them. Since the introduction of the relapse prevention model, discussion with clients of the

possibility of relapse has become commonplace. In fact, the term "relapse prevention" is so well known it has been applied to many other forms of treatment, possibly because it can be asserted the virtually all treatments are intended to prevent relapse. For example, the trade magazine *Alcoholism and Addictions* features a center section titled "Relapse Prevention" that has nothing in common with Marlatt's model except the name.

Relapse management stresses the importance of dealing with relapses that occur by (1) minimizing the negative impact of the relapses and (2) construing relapses as learning experiences rather than as disastrous personal failures. This can help to lessen the significance of relapses that do occur as well as to maintain the subject's motivation for a successful long-term outcome. Considered from this perspective, recovery is viewed as a learning process rather than an all-or-none phenomenon. The occurrence of initial problems and how they are managed are seen as important determinants of long-term outcome. Continued success experiences are expected to lead to long-term maintenance of behavior change. Similarly, continued failure experiences are expected to rapidly dissipate treatment gains.

Relapse management has two key components. The first concerns how *clients react to the onset of a relapse*. The important point for clients to grasp is that the quicker the relapse is interrupted, the fewer risks they will take, and the fewer consequences they will suffer. Clients are told that just because they have crossed the line does not mean that they must stay there. They can minimize the harm by cutting the episode short.

The second relapse management component deals with the e*ffects of a relapse on future motivation for change* in terms of the way a person deals with a relapse that has occurred. Here clients are encouraged to view the relapse as a learning experience, to see what lessons can be gained from the experience to help prevent future relapses, and then to put the relapse in perspective and get it behind them (i.e., to view it as a setback along the trail to recovery, not as a reason to abandon attempts to change). The dual emphases on a taking a long-term perspective on recovery and on dealing with adverse episodes constructively complement self-management treatments and are consistent with self-help strategies. Thus, relapse prevention can be viewed from a motivational perspective as fostering clients' perseverance in their attempts to change their behavior.

The relapse prevention approach, which had its origin in research conducted primarily with chronic alcoholics (Marlatt, 1978), requires some modifications to be consistent with the research findings relating to problem drinkers. In terms of alternative responses to drinking in high-risk situations, the guided self-management approach focuses on helping clients identify and use existing coping skills rather than providing clients with skills training. Encouraging clients to identify and capitalize on their own strengths and coping styles is less value laden than a coping-skills training approach, and thus it might be more appealing to problem drinkers. For example, if confronted with social pressures to drink, a person could do several things: (1) resist those pressures by being appropriately assertive; (2) resist those pressures by less assertive means (e.g., "My doctor told me that I shouldn't drink"); (3) leave the situation; (4) enlist the help of others (e.g., spouse, friend) in resisting the pressures; or (5) ignore the pressures. While any of these methods might be effective, coping-skills training requires designation of what skills would be good to acquire. The self-management approach, however, allows clients to determine the type of response they believe will be most effective and feasible for them. Thus, one important way that the guided self-management treatment approach differs from traditional relapse prevention is that it does not involve explicit skills training.

The traditional relapse prevention approach also needs to be modified to include moderation goals. For clients with a reduced-drinking goal, instead of any drinking constituting a violation of intention (i.e., the abstinence violation effect), it is drinking that violates limits specified by the client's goal that constitutes the rules violation effect (Larimer & Marlatt, 1990).

Evaluations of Relapse Prevention

In several recent reviews of the relapse process, Saunders and Allsop (Allsop & Saunders, 1989a; Allsop & Saunders, 1989b; Saunders & Allsop, 1987; Saunders & Allsop, 1992) have discussed the advantages and disadvantages associated with the relapse prevention model. One major problem is that although the model has intuitive appeal, it has not been adequately tested (Saunders & Allsop, 1987). Another is that "there is a very real difference between being skill deficient and having skills but deciding not to use them" (Allsop & Saunders, 1989b, p. 18). A skills deficiency would suggest the use of a skills training intervention, whereas a failure to use skills would suggest the need for a motivational intervention. There have been relatively few evaluations of the efficacy of relapse prevention, and little

work has attempted to evaluate the unique contribution of the cognitive aspects of relapse prevention procedures. Almost all of the investigations have involved social skills training as the primary relapse prevention procedure. Those few studies that have evaluated the relapse prevention model will be reviewed here.

Although that report did not use the term "relapse prevention" when it was published the best known relapse prevention study is Chaney, O'Leary, and Marlatt (1978). In addition to their regular treatment, chronic alcoholics in inpatient treatment were randomly assigned to participate in social skills training (relapse prevention), to participate in a discussion group where high-risk drinking situations were discussed but skills training was not provided, or to receive no additional treatment. Although the skills-training group did not differ from the other two groups in outcome 3 months after treatment, it had a significantly better outcome (i.e., decreased duration and severity of relapse episodes) at 1 year posttreatment. This finding is consistent with viewing recovery as a learning process (Marlatt, 1983).

In Norway, Eriksen, Bjornstad, and Gotestam (1986) randomly assigned groups of 12 alcohol-dependent clients to receive either eight sessions of social skills training in addition to a standard alcoholism group counseling treatment or only the standard treatment. Subjects who received skills training had their first drink a mean of 51.6 days following treatment compared to 8.3 days for control subjects. They drank about one-third less alcohol per week than the control subjects. Also, their consumption was comparable to Norwegian norms and was judged by their significant others as socially acceptable.

Ito, Donovan, and Hall (1988) compared the effects of two aftercare conditions (a cognitive-behavioral skills-training relapse prevention or an interpersonal-process orientation) for hospitalized male alcoholic veterans. At the 6-month follow-up both groups showed comparable outcomes on several variables, although there were trends favoring the relapse-prevention treatment. Sjoberg and Samsonowitz (1985) similarly compared an outpatient drinking-related coping-skills program with a counseling program focusing on strategies for abstinence and found no difference between groups.

Another randomized controlled study of the relapse prevention method utilizing skills training has been reported by Annis (Annis, 1986b; Annis & Davis, 1988a, 1988b). In this study, 41 clients who

participated in a program for employer-referred problem drinkers received eight outpatient counseling sessions of relapse prevention treatment over 3 months. Although the clients improved significantly over 6 months of follow-up, there was no comparison group. Thus, it is not possible to evaluate the relative effectiveness of the relapse prevention approach.

A positive finding for relapse prevention has been reported by Saunders and Allsop (1992), who compared 60 problem drinkers randomly assigned to a cognitive-behavioral relapse prevention treatment group and a routine treatment group, a relapse-discussion group and a routine treatment group, or a routine treatment group only. At 6-month follow-up, subjects who had been in the relapse prevention group had longer periods of abstinence, fewer symptoms of dependence, and fewer and less severe alcohol problems. At 1-year follow-up, the time to first drink and time to first heavy-drinking day were significantly longer for the subjects who had received relapse prevention than for the other subjects in the study.

The relapse prevention model has been extensively evaluated in the area of smoking research. Consistent with the model, Condiotte and Lichtenstein (1981) found in a prospective study that a large proportion (about 80%) of subjects who relapsed "appeared to demonstrate aspects of the abstinence violation effect" (p. 656). Consistent with findings by Cummings and his colleagues (1980), a microanalysis of relapse situations found a significant relationship between subjects' posttreatment perceived self-efficacy (i.e., confidence in their ability to cope) and the types of situations in which relapse occurred: Relapses occurred in situations for which subjects had reported low self-efficacy. Shiffman (1982), in a study of relapse of ex-smokers, found data supportive of Marlatt's model. However, while situational antecedents were important, they were not sufficient determinants of relapse. Within risk situations, the most important determinant of relapse appeared to be whether subjects performed any coping responses; those who performed any coping response were less likely to relapse. This finding provides indirect support for a motivational component for relapse prevention rather than for specific skills training.

Killen and his colleagues (Killen, Fortmann, Newman, & Varady, 1990)evaluated a relapse prevention component among behavioral treatments and nicotine gum interventions for smokers and found no effect for the relapse prevention component. They reported that "although participants in the

trial said they liked the relapse prevention strategies presented to them and that they 'made sense,' subjects failed to put such strategies into practice" (p. 90).

Roffman and his colleagues (Roffman, Stephens, Simpson, & Whitaker, 1988) reported preliminary findings for a relapse prevention treatment of marijuana dependence. The subjects were generally well-educated, employed, and in their 30s. The relapse prevention treatment (n = 54) was compared with a social-support treatment (n = 56) that emphasized developing and using a support network. Treatments involved ten group sessions and booster sessions at 3- and 6-month follow-ups. At 1-month follow-up, abstinence rates did not differ significantly between the groups. At a 3-month follow-up, for subjects run later in the study, the social-support subjects had a better abstinence rate than the relapse prevention subjects. However, at the 6-month follow-up the difference was no longer significant, despite the fact that slightly more subjects were abstinent in the social-support group«(31.3%) than in the relapse prevention group (24.7%). At a long-term follow-up (30 months), there was no significant difference in outcome between groups (Roffman, Stephens, & Simpson, 1990), leading the authors to conclude that they had found no advantage for the relapse prevention group.

Finally, Hawkins, Catalano, and Wells (1986) randomly assigned 70 drug abusers in a therapeutic community to a skills-training intervention, and another 60 to the regular therapeutic community program as a control condition. Experimental effects were noted for the skills-training group on within-treatment measures of social skills, but no between-treatment outcome data were presented.

Other studies have examined the relapse prevention model but not the relapse prevention treatment. Hall, Havassy, and Wasserman (1990), for example, studied 221 alcoholics, opiate users, and cigarette smokers who were followed after treatment for either 12 weeks or until they had relapsed with their problem drug for 7 consecutive days. The authors found that relapse precipitated by negative moods could only be assessed after the fact (most studies of relapse precipitants have used retrospective assessments). When the relationship between negative moods and substance use was examined in a prospective manner, no association was apparent. This suggests that rather than precipitating relapse, negative moods may simply be a convenient attribution made by clients when they are attempting to explain why a relapse occurred. Also, clients with the most restrictive goal (i.e., abstinence) were less likely to lapse, and less likely to progress from a lapse to a relapse, than were clients with less-

demanding goals. This finding is contrary to the relapse prevention model, which predicts that a stringent goal would increase the probability of a relapse after a slip.

In another study testing the relapse prevention model, Birke, Edelmann, and Davis (1990) examined whether illicit drug users would show an abstinence violation effect. They concluded that factors such as health and criminal involvement were more important variables in predicting drug use and relapse than were cognitive attributions about an initial use.

In evaluating the various tests of the relapse prevention approach, it is clear that in most cases relapse prevention treatment, as it has been tested to date, has been inextricably confounded with other treatment procedures, most notably skills training. To some extent, a certain amount of confounding is unavoidable. For example, it is not clear how one could enact a relapse prevention treatment that did not include a functional analysis of drinking behavior. However, it is possible to conduct relapse prevention in the absence of skills training. Also, while there is support for using a skills-training version of relapse prevention treatment with severely dependent alcohol abusers (i.e., such individuals may be deficient in certain skills) (Twentyman et al., 1982), to date no studies suggest that less severely dependent alcohol abusers have similar deficits. Indeed, the finding that short-term treatments can be efficacious for such persons suggests that most of these individuals have adequate coping skills, which, with some guidance, they can use successfully to deal with potential or actual relapse situations.

In conclusion, while the studies published to date provide limited support for the effectiveness of social skills training for alcohol abusers, the findings are inconsistent. Also, the unique contributions of the key cognitive features of the relapse prevention approach have not been evaluated, except in our own research, which will be discussed later in this book. The lack of tests for the cognitive aspects of relapse prevention is unfortunate because it is the emphasis on cognitive aspects of relapse (i.e., how relapses are construed) that primarily differentiates the model from previous behavioral treatments. There is also a need to evaluate whether relapse prevention has general applicability or should be restricted to clients who tend to catastrophize about a lapse.

Summary and Integration

Based on the positive track record of brief interventions, and realizing that the effectiveness of such approaches cannot be attributed to intensive skills training, it is clear that many people have sufficient resources to modify their behavior patterns if they wish. The guided self-management orientation is intended to facilitate self-change by encouraging people to identify reasons for changing, by providing general strategies for achieving and maintaining change, and by providing advice. The emphasis is on helping people to identify their own strengths and resources and to capitalize upon those assets as they seek a life free from alcohol problems. The intervention is intended to be minimally intrusive on a person's life-style. A strong emphasis is placed on practicality, that is, developing treatments that can be readily applied by clinicians and other health care providers in community-based treatment programs. The majority of the treatment in guided self-management studies was conducted by clinicians rather than researchers.

In the following chapters, the major components of the guided self management treatment program arc described. While the treatment involves a small number of sessions, it is most appropriately described as a "program" of treatment. This is because it gets off to a running start with the first treatment components being set in place at the assessment, and it continues past the formal sessions if a need for further treatment is indicated. There is no "magic number" of treatment sessions for any given individual. Different people will have problems of differing complexity, will have different life circumstances, and will be capable of different rates of change. Flexibility and adapting to the needs of each client should be the major consideration when applying the procedures described here. Although the treatment is discussed as a set of procedures, we wish to stress that it is an approach rather than a regimen. The guiding themes of the approach are its emphasis on increasing clients' motivation (commitment to change) and on finding ways to help people help themselves.