Outcomes and Afterthoughts

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Because this book is a treatment manual and not a scientific report, it does not contain detailed treatment outcome data about the guided self-management treatment approach with problem drinkers. Some discussion of those findings is relevant, however, and is included to the extent that it is instructive or raises important clinical issues. The findings discussed here derive from our evaluation of a two-session (90 minutes each) version of the treatment.

While the guided self-management approach has been evaluated in one major study, other studies have also evaluated variations of this approach (L. C. Sobell & M. B. Sobell, 1992a; Romach et al., 1991; Sobell, Sobell, & Leo, 1990; Sellers et al., 1991). It is important to note that many of the current treatment components have previously been well validated in other behavioral treatments. Functional analysis, for example, is a cornerstone of behavioral treatments for alcohol problems. In many ways, the guided self management approach can be viewed as a standard behavioral treatment with a strong motivational component. In evaluating the treatment it is important to examine outcomes and to take note of clients' perceptions of the appropriateness of the approach as well as the therapists' comfort in delivering the procedures. Since it is common in the alcohol field to find few substantial differences in effectiveness between methods (when pretreatment status of clients and other potentially confounding factors are controlled), matters such as attractiveness to clients and cost effectiveness are important determinants of treatments of choice.

Three types of findings will be discussed: (1) treatment outcome data— how clients fared during and after treatment; (2) interviews conducted with former clients about their views of the treatment; and (3) interviews conducted with therapists who used the treatment. Each perspective contributes to the total picture of what happened to clients who participated in a guided self-management treatment. The findings presented are from the major evaluative study of the approach.

The Topography of Outcomes

The outcomes of clients treated by the guided self-management approach are generally consistent

with findings for other behavioral treatments with problem drinkers (Sobell, Sobell, & Leo, 1990). For example, in the year following treatment, the total number of drinks consumed was reduced by approximately 54%. There were significant increases in the number of abstinent days and the number of days of drinking four or fewer drinks, and there was a significant decrease in heavy-drinking days (i.e., ten or more drinks). Nevertheless, ideal outcomes were relatively rare. As an example, in most cases there were at least a few days of drinking beyond the recommended limits. In terms of consequences, they were greatly diminished, although some still occurred. Overall, this study found major reductions in drinking and significant improvements in functioning.

The differences in drinking took place over the course of treatment, and the average length of time from assessment until the end of the second treatment session was about 5 weeks. The changes were then sustained and even improved somewhat over the first year of follow-up. Clients' subjective judgments of how they fared were similar to their outcome data. These data are graphically displayed in Figure 12.1. This figure portrays clients' ratings of their drinking problem severity for the year prior to treatment and the year following treatment using the categories described in Table 3.2.

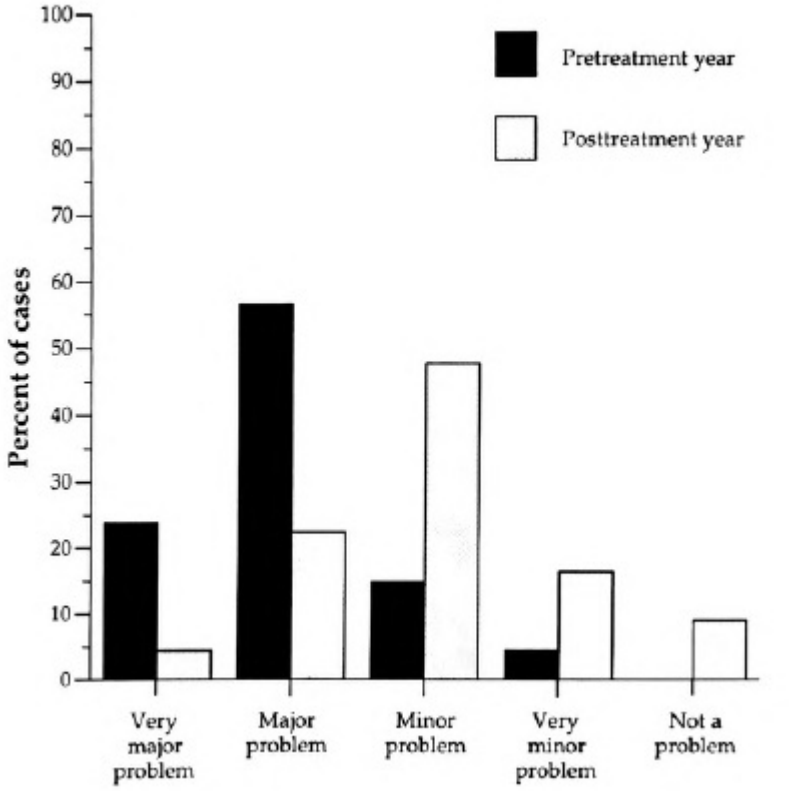

Figure 12.1 shows that the treatment outcomes for all clients can be described as improved. There is a clear and major shift along the dimension of problem severity. Thus, while before treatment the vast majority of clients classified their drinking problem as Major or Very Major, after treatment most clients classified their drinking problem as Minor and about a quarter described themselves as problem free (a rating of Very Minor was operationally defined as having experienced no negative consequences).

Our major evaluative study found that the inclusion of relapse prevention components in the treatment did not confer any advantage in terms of treatment outcome (Sobell, Sobell, & Leo, 1990). Moreover, data from the study indicated that only 10% of the clients reported that they tended to drink

heavily on the day following a day of heavy drinking (i.e., they did not drink in a manner that conforms to explanation by the relapse prevention model). Despite the findings, all therapists felt it was awkward to conduct the treatment without mentioning relapse prevention issues, and clients who received the relapse prevention version of the treatment saw those components as valuable. Considering that there was no difference in the amount or intensity of treatment when cognitive relapse prevention procedures were incorporated, it is recommended that they be retained. However, therapists should be careful in how the likelihood of relapse is communicated to clients. Problem drinker clients should not be led to expect that relapse is so common as to be nearly inevitable. The emphasis should be placed on maintaining commitment to change even if setbacks occur. The aspect of relapse prevention that is most consistent with a motivational intervention is the importance of remaining committed to recovery over time.

In terms of treatment goals, very little change occurred over the course of follow-up. About 10% to 20% of clients changed their goal sometime between the assessment and the end of the first year of follow-up. Of these, about one third changed from abstinence to a reduced-drinking goal, and the remainder changed from reduced-drinking to an abstinence goal.

Level of education emerged as a factor in two ways. First we found that better-educated clients preferred a goal of reduced drinking. Those clients who selected a reduced-drinking goal at assessment were significantly better educated (mean education = 15.3 years) than those who selected abstinence (mean education = 12.8 years). Second, we found that better-educated clients preferred to choose their goal. In another study we conducted (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992), clients with at least some university education were significantly more likely to prefer to select their own goal (78%) compared to clients with less education (51% preferred goal self-selection). This suggests that a program such as guided self-management may have particular appeal to better-educated problem drinkers.

About half of the clients in the guided self-management treatment reported at their 2-year follow-up interview that the amount of treatment had been sufficient and that the overall outcome of the treatment was quite positive. The rest felt that the 2-session treatment had been too brief, and about the same number reported they had sought further treatment after their second session. An analysis comparing the drinking of clients who did not seek further treatment with those who did found some

differences between the groups. Those who sought further treatment had lower levels of abstinence prior to treatment and smaller increases in abstinence days than those who did not seek further treatment. Also, while the percentage of heavy-drinking days (i.e., ten or more drinks) prior to treatment did not differ between the groups, those who did not seek treatment showed a marked decrease in heavy drinking after treatment compared to little change for those who sought additional treatment.

Those clients who sought further treatment most frequently received that treatment at the same agency that had provided the formal guided self management treatment, and they uniformly reported that the additional sessions were "helpful." Attendance at Alcoholics Anonymous meetings, even when sporadic, was reported as the next most helpful additional treatment.

That about half of the clients felt that their brief treatment experience was sufficient suggests that a substantial number of problem drinkers respond well to a brief self-management oriented approach. The use of a brief self management treatment for persons whose problems are not severe and who are accepting of the approach is a sensible "front end" approach to providing services for problem drinkers. That about half of the clients felt that they needed additional treatment communicates that it is also important to provide supplementary services for these clients.

Client Perceptions of Guided Self-Management

An important but seldom investigated aspect of most treatments is how they are perceived by clients. Part of the 2-year follow-up interview for the guided self-management treatment asked clients to evaluate various components of their treatment. If a client did not recall a component, they were reminded of it before being asked for an evaluation.

Treatment Components

Clients' recall of procedures and aspects of the treatment varied from component to component. The best-recalled components were the homework assignments (recalled by 92%) and the use of self-selected goals (91%). Both of these components involved clients actively completing forms. Recall of other aspects of the treatment (e.g., number of sessions, identifying triggers) was somewhat lower (70% to 80%). However, only 21 % recalled that the treatment was specifically designed for problem drinkers.

And of those treated with the relapse prevention version of the treatment, only 23% recalled the emphasis on a long-term perspective on recovery, and only 47% recalled that slips should be construed constructively.

Clients were asked to rate the helpfulness of each component. All components were evaluated as helpful by at least a majority (55% to 85%) of the clients interviewed. One component, however, stood out among all others: The therapists were rated as helpful by 84% of all clients. The two components with the lowest helpfulness ratings were the readings (55%) and the follow-up (56%).

Clients' Outcome Attributions

An important question for motivational interventions concerns clients' attributions about what they feel contributed to their outcome. Clients were asked to comment about whether and to what extent (i.e., Very Much, Somewhat, or Not at All) each of the following contributed to their outcome: themselves, the treatment program, their therapist, and other factors ("things outside of treatment that occurred in your life"). Consistent with a motivational intervention, 73% of the clients stated that they had contributed Very Much to their outcome, whereas 41% rated the treatment as having contributed Very Much, and 33% said that their therapist contributed Very Much to their outcome.

Almost half (48%) of the clients rated other factors as having contributed Very Much to their outcome. Clients' descriptions of other factors were more often reported as positive than negative factors. Three types of positive factors emerged. The most prevalent factor was social support. This finding is consistent with studies of natural recovery (recovery without treatment), where the most prominent factor reported as helping persons maintain their recoveries has been support by their spouse, family, and friends (Sobell, Sobell, & Toneatto, 1992; Sobell, Sobell, Toneatto, & Leo, in press). The other two types of positive other factors contributing very much to clients' reports of outcome were additional treatment and changes in circumstances. Table 12.1 provides a summary of these positive other factors.

TABLE 12.1.

Positive Other Factors Contributing Very Much to Clients' Reports of Outcome

Social Support

Continued encouragement from their spouse

Verbal admonitions to stop drinking by family

Support from friends in the form of not encouraging drinking

Desire of the client to maintain a relationship by resolving drinking problem

Additional Treatment

Changes in Circumstances

Job circumstances (e.g., changed from one job to another; positive changes at work) Marital status (e.g., divorced from a bad marriage)

Other (e.g., became more settled by having a baby; bought a house; made new friends; went back to school)

A small number of negative influences were also identified. These focused on marital problems (e.g., divorce, separation, custody problems).

Again, the most important point about clients' attributions is that three quarters saw themselves as Very Much responsible for their outcome. This is very consistent with a motivational treatment.

Goal Self-Selection

Clients were asked whether choosing their own goal was a Good Thing or a Bad Thing. Eighty-one percent of the clients felt that being able to choose their own goal was a Good Thing. The main reasons given by clients for this were: (1) resistance to having decisions forced on them; (2) that they felt more motivated to achieve a self-set goal; (3) that they liked to take responsibility for decisions affecting themselves; and (4) that self-selection was a realistic procedure in that they had ultimate responsibility for their behavior. Examples of clients' responses (some paraphrased and some verbatim) to the open-ended inquiry about why they said choosing their own goal was a Good Thing follow:

· "Can set reasonable goal which I can achieve, accomplish."

· Individuals must ultimately assume responsibility to control their drinking, a good initial step.

· May not be as motivated to listen to other's advice.

· "Wouldn't stick to goals if they were forced on me; you have to make up your own mind."

· "Placed responsibility on me."

· "You're your own boss; not being told what to do."

· Suited the type of person she is—wouldn't respond to someone else telling her what to do—responsibility was up to her to meet her own goals.

· "Up to you to be able to stop yourself; no one else can tell you what to do."

· "Feel you're in control, able to set own limits."

· Doesn't take well to someone telling her what to do; felt that self-determination was the only approach.

· "Not so much choosing, as a realistic goal was coached out of me. I would have to change whole personality type to accept external goals and values."

· Liked having the freedom of choice (with advice). Type of person who has personal integrity such that if he makes a commitment (to himself, especially) he would strive to achieve it.

· "Because if you see a goal not working, then you have the ability to change it versus being told there's only one way to go."

A few clients rated goal self-selection as a Bad Thing. These clients responded that they had decided they needed a more direct approach because they either felt unable to exercise control over their behavior or felt they might make a poor decision, especially early in treatment.

Clients were also asked what types of people should choose their own treatment goals and what types of people should have their goals assigned by their therapist. Clients described good candidates for goal self-selection as persons who have less-severe drinking problems, have more self-determination, are highly motivated, are used to working earnestly toward goals, are honest with themselves, who have a history of prior control, and who have resources to call upon. Examples of clients' responses (some paraphrased and some verbatim) to the question about what types of individuals should choose their own treatment goals follow:

· "Those that are honest with themselves and who know what their limits are."

· "Those with their physical and mental health and some external resources. "

· "Less acute, milder drinking problems; capable of running their lives, making decisions more."

· "Clients who are able to deal with working toward goals."

· Those who are in early stages and might be able to work toward a moderation goal.

· People that can self-manage, who have motivation, and are not severely dependent.

· "Someone who is accustomed to making their own choices, if they've decided they have a problem."

· "People who have less-severe problems; depends how good people are at controlling their drinking."

· Still have some "support," e.g., emotional, financial, going for them.

· "Ones who aren't as dependent or people who have more self-determination."

· People who have the resources or strengths to set their own goals and work toward achieving them.

The types of persons that our clients thought should have their goals assigned by the therapist were in many ways the opposite of those they thought should select their own goals. Those seen as appropriate for therapist goal assignment were described as more severely dependent, unable to take care of themselves, in need of strong direction, and low in willpower, support, or ability to help themselves. Rather than focusing on a perceived inability to control drinking as the major feature dictating which type of individual should have their goals assigned by the therapist, many of the statements described persons who are responsive to authority and look to others for direction. Examples of clients' descriptions (some paraphrased and some verbatim) of features of individuals who should have their treatment goals set by the therapist follow:

· More severe alcohol problem; more negative effects of drinking; unable to take care of themselves.

· "Depends on pattern—long history of alcoholism—difficult stopping—unrealistic."

· "People who need someone in authority."

· "Repeat clients [i.e., in treatment] who have shown that they are unable to work towards self-set

goals."

· "Those whose physical and mental health is severely damaged and have no motivation or skills in language, job, society."

· "Self-admitted alcoholics."

· "Those who are habitual drinkers or have severe problems."

· Severely dependent clients and those without outside support or resources (e.g., no job, family).

· "People who like to fool themselves."

· "People who lack self-control and have a severe drinking problem— severity. "

· "People that need more direction."

· "People accustomed to taking other peoples' definitions of themselves."

· "People more comfortable in authoritarian situations."

· "Very severely dependent people who may not be able to deal with their problem without someone else telling them what to do."

· People who don't have any "support."

· "People who aren't able to set goals and need an authoritative voice to tell them what to do."

• "People who want to be told what to do; who need authoritative influence."

Improving Guided Self-Management

Nearly all (97%) of the clients interviewed said that the guided self-management treatment should continue to be available. When asked how the treatment could be improved, the most frequent recommendation was that additional treatment should be provided, although this was often mentioned in terms of "aftercare" sessions with the therapist. Examples of the comments by clients (some paraphrased and some verbatim) about ways to improve the treatment follow:

· "Regular support group with staff would have been helpful but not in terms of the AA approach"—dislikes AA philosophy and setup.

· More follow-up with therapist.

· Feels that group sessions would be helpful, i.e., sharing experiences with others trying to abstain from or control their drinking. "Like AA but not rigid."

· More treatment sessions.

· "For interested clients, teach them about the medical effects of alcohol on their bodies and to recognize effects of alcohol."

· More therapist contact, e.g., phone contact during follow-up to see how client is doing.

· Should be stressed that this program is no guarantee, i.e., "that it is not for everyone and that there are other treatment options if this program wasn't working."

· Interaction with another person, i.e., clients, to exchange experiences. "Lets you know you're not alone; comparison as a motivator."

· More flexibility in terms of amount of treatment contact, depending on the individual's needs.

· More contact with therapist and with follow-up.

· More structured, more motivational, more directive treatment.

Other Observations

Clients were given an opportunity to make additional comments if they wished. Comments selected because they are particularly meaningful in relation to the nature of the intervention follow:

· [Therapist] was very helpful. Remembers that she did more listening than speaking, letting client talk herself out, facing up to problems that she may not have wanted to admit. Very happy about what the program did for her. Although she had some slips in the beginning, she is now abstinent with no desire to drink, realizing she was the only one who could make changes in her life.

· "Analytical approach" [identifying problem situations and triggers and how to deal with them] suited his way of dealing with his life. Also liked the "soft sell" of the program, that is, not labeling patient as an "alcoholic" but talking in terms of negative consequences and how to deal with problems. Liked the emphasis that recovery wasn't black and white (success/failure), that slips may occur and not to overdramatize it and not to give up.

· The staff were nonjudgmental. Feels that the program didn't work for her. Perhaps she lacked enough motivation to change "on her own." Efforts to stick to drinking goals took too much effort. Found goals to be somewhat artificial. Realized that abstinence may be the only way for her because even having one drink after abstinence can lead to overindulging.

· "It helped me realize that total abstinence was my only hope."

· Program wasn't intensive, which fit his life-style—work schedule, problem-solving approach.

· It suited her life-style, cognitive style. She likes to be in control, analyzes things in her life, and likes things orderly. The fact that from the first step of filling out questionnaires in assessment, which helped her see patterns in her drinking, to being able to set goals that matched her view that responsibility was on her, to the emphasis of doing it on her own, and the nonjudgmental approach of everyone that she came into contact with, which suited her view of wanting to be in control and not having others tell her what to do—"all this was very good." She commented that not many people know about [the facility], and many people like herself would probably not pursue treatment because of stigma and of "alcoholism" and only knowing about treatment for severely dependent people, "alcoholics."

· Felt that this program was geared toward the middle class with their associated beliefs, toward a self-assertive "pull up your bootstraps" [sic] type of person and, therefore, not appropriate for people who are more passive. He described himself as taking a more "passive random" approach to life and the structured behavioral assertive orientation did not appeal to or fit in with his way of living.

· Filling out the questionnaires and homework assignments was good because you put the problem down on paper and you can look at it. "You see things that you normally wouldn't be aware of just experiencing the problem."

· Liked how the program was tailored to her individual needs, and the problem-solving strategy suited her. What was very helpful but difficult to do were the homework assignments. To have to write things down and have it in front of her was enlightening. Exactly what she needed to deal with her problem.

· Nonjudgmental. Had a friend who went to [another facility] and was told by their staff that he didn't have a drinking problem and therefore wasn't eligible for treatment. He liked the fact that [this facility] didn't do that and was able to help him even if his problem wasn't deemed "serious."

· Best part of the program was being able to talk to [her therapist] about her drinking without feeling that [the therapist] was being judgmental or without being afraid of censure. The

cognitive approach was compatible with the way she thinks, and she appreciated the fact that the program treated her with respect, that is, that she was intelligent and resourceful enough to deal with her drinking.

- The treatment program provided a framework for dealing with his problem that was very compatible with the way he manages his life and business, that is, using problem-solving strategies, setting objectives for himself to achieve.

- Did not see how others in the program could manage to deal with their problems on their own (self-management), as she found it very difficult. She said perhaps if a person had a good "support" system (e.g., friends and family), they could do it. Since she didn't have that kind of support, she found it difficult.

Therapist Perceptions of Guided Self-Management

A final perspective on guided self-management treatment comes from the therapists who conducted the treatment. Four therapists who were involved in a treatment study were interviewed. Our own views are also relevant because we were among the therapists who conducted the treatment with these clients. The interview questions and answers are summarized below.

The therapists were unanimous in their recollections that prior to the study they had concerns that the treatment might not be sufficient. This concern, however, was addressed by allowing clients to request further treatment after the required sessions had been completed. The therapists also noted that the clients differed somewhat from the regular flow of outpatient clients in that their problems were less severe and that they were more socially stable.

Therapists' Impressions

As with the clients, therapists were asked to evaluate the helpfulness of the various instruments and procedures. The assessment instruments that received the highest ratings by the therapists were the Inventory of Drinking Situations, which was described as accelerating treatment planning, and the Clinical Assessment Summary, which provided a quick reference to the essential features of the case. The Goal Statement, which was also rated highly, was seen as helping clients take responsibility for setting their own goals. The drinking Timeline was evaluated as providing a longitudinal picture of the client's

drinking: In one display the Timeline captured drinking levels, patterns, and trends over time and often had notations about life events related to the drinking. The Timeline was seen as helpful to clients in terms of illustrating patterns in their drinking and calling their attention to the extent of their drinking.

With regard to treatment components, the readings, especially the diagram of Mount Recovery, were highly rated. The procedure of goal self-selection was also seen as very valuable. One therapist described completion of the Goal Statement as a "ritual of commitment and self-review." The availability of further treatment after the second session was seen as an essential "safety net." Two other highly regarded treatment components were the relapse prevention procedures and the problem-solving guidelines. One therapist described the problem-solving guidelines as making the cost of changing clear to clients.

When therapists were asked to identify three components that they liked most about the approach and procedures of the program, they identified: (1) the readings, homework, and Goal Statement; (2) that the treatment was tailored to persons who were not severely dependent and was oriented toward clients taking responsibility for managing their own affairs; and (3) that the treatment was practical and straightforward.

Therapists were also asked to identify three components of the program that they disliked most. Much of the concern here focused on the brevity of treatment (the 2-session treatment model). The therapists also noted that it was difficult to complete the required procedures in the allotted time for clients who had other concerns (e.g., marital problems). Some of the unhappiness with the shortness of the treatment was related to the treatment's lack of focus on maintenance of change. However, it is important to note that these criticisms of the treatment relate in part to the necessity of standardizing procedures in a treatment research study; in clinical practice procedures can be modified to fit the needs of each case.

Almost all the therapists felt that it would be beneficial to extend the treatment to three or four sessions. It was suggested that a few maintenance (aftercare) appointments be scheduled at the end of the second session that could be subsequently canceled by the client if he or she felt that he or she did not need them. The thinking was that the prescheduling would allow clients access to further treatment

without having to make a request for it.

Therapists were also asked to suggest which types of clients they thought would do well with the guided self-management approach. In general, they felt that well-motivated, socially stable, low-dependence drinkers would be the best candidates. They also felt that the client's educational level was important and availability of supports (e.g., from significant others) were important, and that the person should perceive "choice" as possible and desirable.

All but one therapist, who was no longer working in the alcohol field, responded that they had occasion to utilize guided self-management procedures or materials since the completion of the study. Interestingly, despite being unaware of the results when interviewed, they had a view of the treatment that was consistent with the outcome results. They thought that the approach worked well with some but not all of the clients. They thought that for almost all of the clients in the study it was a good way to start treatment, with access to further treatment being an essential backup provision for those who were not able to change their behavior sufficiently from a brief intervention.

Finally, the therapists noted that clients' ability to analyze their drinking and develop a treatment plan varied considerably. As a result therapists needed to be flexible in the extent to which they devoted time to these matters in the sessions.

On Implementing Guided Self-Management Treatment in Clinical Practice

As with treatment approaches for other types of problems, it is important for therapists to recognize that there are a variety of potentially effective treatment strategies and procedures that constitute their overall therapeutic armamentarium, with the approach to any specific case determined by the particular features of that case. Considered in this way, guided self-management is a good first treatment of choice for some people. It is low cost, minimally intrusive, and consistent with maintaining or increasing clients' self-esteem. It also is clear that many problem drinkers are quite satisfied with a self management, cognitively oriented treatment approach that includes goal self-selection. As we stated earlier, there will be some problem drinkers who do not do well with such an approach, even though they might begin the treatment thinking that it would be a good match. Thus, clients' functioning should be monitored after

the formal sessions are completed, and additional or alternative treatment should be available for those who continue to have problems.

Although our research found no advantage for including relapse prevention as part of the treatment, it is notable that the therapists found it awkward to conduct therapy without it. However, those clients who received guided self-management without the relapse prevention components did not perceive the treatment as awkward. From the standpoint of clinical practice, it seems reasonable to inform clients that the road to recovery might well have its ups and downs. Thus, we still recommend inclusion of the relapse prevention components and have presented the treatment that way in this book.

In summary, our presentation of guided self-management treatment has focused on how to conduct the treatment in community treatment settings rather than in research projects. There is no rigorous order to the procedures, no requirement that all procedures be used or used in the same intensity with each client, and no arbitrary specification of how many sessions are necessary. Guided self-management is a motivational intervention where the aim is to enable clients to solve their own problems. Motivational interventions are a recent development among treatments for alcohol problems (Miller & Rollnick, 1991), and as such there is abundant room for further innovations. The essential thing is that clinicians keep in mind the principle of helping clients help themselves.