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Cognitive/behavior treatment program for use with American Indian alcohol abusers

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A COGNITIVE/BEHAVIOR TREATMENT PROGRAM

FOR USE WITH

AMERICAN INDIAN ALCOHOL ABUSERS

By

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B.A., Hope College, 1974

M.Div., Western Theological Seminary, 1977

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ABSTRACT

The use and abuse of alcohol by American Indians has a history of approximately 150 years which, when analyzed, can define cultural and social factors which are the antecedent conditions to American Indian drinking. Eight appear particularly important. 1. American Indians learned to drink rapidly in order to avoid legal apprehension, and on two-thirds of the reservations they continue to do so for this reason. 2. Excessive drinking by Indians has usually been occasion for conflict with the white man or exploitation by him. 3. Prolonged intoxication and drinking with intoxication as a primary goal by Indians is a result of frontier Anglo-American modeling. 4. The American Indian views his own intoxicated behavior as behavior for which he cannot be held responsible. 5. Acculturation at present appears to maintain cultural stress sufficient to elicit continued abusive drinking in some tribal groups. 6. Much excessive drinking takes place in a peer drinking group which overtly and covertly reinforces alcohol abuse. 7. Alcoholism as a diagnosable pathology does not appear to be greater among Indians than among whites. 8. The social and personal consequences to alcohol abuse are central to the problem.

Current treatment strategies take cognizance of these and other cultural issues peculiar to the American Indian minimally, if at all. This, in part, could account for their less than satisfactory rate of success. Detoxification, Alcoholics Anonymous and disulfiram appear thereby inadequate by themselves to treat American Indian alcohol abuse.

A review of the behavioral and cognitive literature indicates several treatment components which may be useful in the treatment of American Indian alcohol abuse: self-monitoring of alcohol ingestion, drinking-stimulus control training, rate-reduction training, relaxation training, social skills training, covert rehearsal and covert reinforcement.
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A COGNITIVE/BEHAVIOR TREATMENT PROGRAM

FOR USE WITH

AMERICAN INDIAN ALCOHOL ABUSERS

INTRODUCTION

A psycho-cultural conceptualization of alcohol abuse among American Indians will be offered in the first chapter. The second chapter will review previous attempts at treatment of alcohol abuse among American Indians, and will suggest why they have been less than totally adequate. A review of the literature describing behavior and cognitive treatments for alcohol abuse among predominantly Anglo-American populations will be included in the third chapter. The fourth chapter will then provide a rationale for the cognitive/behavior treatment, outlining specific features of the American Indian cultural situation which can be utilized therapeutically by the treatment. In the fifth chapter the proposed treatment is outlined in sufficient detail to be of immediate utility. The sixth and final chapter will note some procedural and logistical difficulties in implementing such a program along with some possible solutions, with reference to a pilot attempt to use this program in Missoula, Montana.
A Conceptualization of American Indian Alcohol Abuse

Firewater myths and the drunken Indian are endemic to Western American folklore. In the late nineteenth century Abbé Belmont (1952) noted that the Ottawa were "addicted" and "passionately attached to" brandy, at the same time describing with ill-concealed distaste the excesses which occurred when they congregated solely for the purpose of drink. Generations of experience and stories have rendered a prevalent caricature of the American Indian as constitutionally incapable of controlled or moderate drinking (Stratton, 1973), a view which is apparently shared by a large number of American Indians (Leland, 1976).

The American Indian's involvement with alcohol is intriguingly richer than a simple caricature. The traffic of alcohol from whites to American Indians probably began with their first interactions, and was perhaps at first a friendly gesture (Robinson, 1974).

As early as 1802 an Iroquois chief, Little Turtle, had recognized the socially deteriorative effects of alcohol upon his tribe and issued a verbal plea to President Thomas Jefferson that the sale of alcohol to Indians be prohibited.
(Snake, 1976). A congressional act in 1802 was insufficient to effect prohibition, so in 1832 the Indian Intercourse Act made it illegal for any white man to trade alcohol to the Indian. Amendments in 1844, 1892, and 1938 added increased restrictions on Indian trade, provided heavy penalties and fines and judicial power to enforce the laws (Snake, 1976). Growing recognition of the law's discriminatory nature eventuated in its repeal in 1953.

The recent legal availability of alcohol to American Indians is a factor not usually considered in the alcohol treatment literature. Until 1953 sale and possession of alcohol was illegal on all reservations. To date, only about one-third of the reservations have legalized alcohol (May, 1977). Legal public drinking of alcohol by American Indians is a relatively recent phenomenon. A natural consequence of the illegal status of liquor is the tendency to gulp liquor rapidly in order to avoid apprehension (Snake, 1976). Early white accounts of Indian drinking include frequent reference to the amazing speed with which Indians could consume alcohol (Winkler, 1966), while a consistently observed pattern in modern American Indian drinking is the rapid rate of ingestion (Lemert, 1968).
Leland (1976), in her review of American Indian alcohol abuse symptomatology, identified traits which were observed by other researchers with sufficient frequency across American Indian populations to be considered characteristic of drinking patterns for that population. The first she refers to as "avid drinking," (p. 34). This is defined as rapid gulping of the first two or three drinks during a drinking session. This mode of alcohol use is found to be predominant or frequently present in accounts of drinking patterns among eleven different tribes. Among the Oglala Sioux drinking is predominantly "avid" beyond the first few drinks.

Provocative research by May (1976) gathered from American Indians living on the Blackfeet, Northern Cheyenne and Crow reservations in Montana indicates that many of the dysfunctional drinking patterns are directly related to legal prohibition of alcohol sales and possession on over two-thirds of the reservations in the United States. His data suggest that hurried drinking to avoid apprehension and long drives on poor reservation roads while intoxicated, in order to return home from bars on the perimeter of the reservation, account for high alcohol-related arrest rates (public intoxication, drunken driving) and mortality rates (cirrhosis of the liver, automobile accidents) among American Indians.
These factors, taken together, suggest the first important characterization of American Indian drinking. Indians learned to drink rapidly in order to avoid legal apprehension, and on two-thirds of the reservations they continue to do so for this reason. On the other one-third, it may be that a behavior learned and socially modeled over generations continues despite the absence of its earlier reinforcing contingencies.

Levy and Kunitz (1974), in their thorough analysis of Navaho drinking, note that for the first 10 to 20 years of exposure to alcohol, the Navaho exhibited no evidence of increased violence or lowering of inhibitions. On the contrary, these factors were evident only after increased exposure to the white man’s way of drinking. By this time liquor was an obligatory prelude to trading with the white man. The introduction of generous quantities of alcohol prior to the signing of treaties or trade agreements was a standard mode of operation used by white negotiators in order to obtain more favorable terms (Winkler, 1968). Thus the interaction between Indians and whites, when lubricated by alcohol, seems always to have been a conflictual relationship. The history of alcohol use among the Flathead of Montana is an example.
In 1860 John Owen, Indian agent at St. Ignatius, complained to federal authorities that the Indian Intercourse Act was impossible to enforce in the area because of widespread illegal bartering of whiskey by whites to the Flathead people (Fahey, 1974, p. 115). In 1863 a wagon train passing through the reservation sold alcohol to the Indians as it progressed. Ambrose, the Flathead chief, exercised his legal Indian prerogative under the Indian Intercourse Act by destroying alcohol found on the reservation. He and a group of other Flathead pretended to attack the train, scattered the whites and dumped all of the whiskey they could find onto the ground. The wagon master later sued and received $8,000 in damages, doubtless from Indian funds (op. cit., p. 118). In 1871 James A. Garfield, sent as a representative of President Grant to the Flathead, wrote in an official report that most of the bad relations between the Flathead and the citizens of Missoula originated from liquor sold to the Indians by whites for a sizeable profit. Throughout the 1870's white traders used whiskey as currency in trade for the increasingly rare buffalo robes the Flathead acquired on their summer hunts to the Yellowstone area (op. cit., pp. 161-163). On November 3, 1880, the Weekly Missoulian reported that whiskey was excessively easy to come by for the Flathead, either from soldiers stationed at Ft. Missoula who wished to cultivate
friendly relations with Indian women, or from white civilians who would buy it wholesale and resell it to the Indians at a considerable profit (op. cit., p. 228). Through the 1890's similar observations were made publicly by Enaes, a Flathead chief, Louison, a Flathead judge, as well as various Indian agents. Liquor could readily be obtained at exhorbitant rates in trade for provisions to lumber camps and fur dealers (op. cit., pp. 244-245).

From all of this a second characteristic of Indian drinking can be described. Excessive drinking by Indians has frequently been an occasion for interracial conflict or exploitation in which the Indian either relinquished to or tried to wrest from the white man autonomous control for the Indians' behavior.

Stereotypical American Indian drinking has been said to involve prolonged intoxication (Ferguson, 1970), and drinking with intoxication as a primary and explicit goal (Brod, 1975). Leland (1976) describes "prolonged intoxication" (p. 93), as a state of inebriation which continues throughout the entire drinking day, or goes on for several days. This might be referred to in the vernacular as a "bender." Evidence for this trait as a predominant mode of drinking behavior was found among 16 tribes.
Mentioned only in passing by Leland (p. 30), another trait is "drinking to get drunk." Alcohol is ingested with the explicit and singular purpose of intoxication. She found this to be a predominant pattern among 13 tribes.

Levy and Kunitz (1974) observe that among the Navaho the opportunity to observe and emulate moderate drinking in whites did not occur until World War II. Prior to that American Indians, especially in the western United States, were predominantly exposed to what might be called a "white frontier" model of drinking in which learned social sanctions were ignored by white settlers in the face of what was perceived by them to be a hostile and unpredictable physical environment (Winkler, 1966). Traders, trappers, miners and cowboys relied upon alcohol as a palliative to an otherwise forbidding lifestyle, and the American Indian, by being exposed to the white model, learned to drink in a similar fashion.

MacAndrew and Edgerton (1969) argue persuasively that this early frontier modeling provided the prototype for excessive drinking, resulting in prolonged and essential intoxication characteristic of American Indian drinking. This early frontier modeling of excessive drinking, with its consequent excessive drunkenness, can be considered a third factor in conceptualizing American Indian drinking.
In addition to the straightforward modeling of overt behavior, frontier white drinking elicited a second attitudinal effect which may be equally important. MacAndrew and Edgerton argue (1969) that when the American Indian viewed the drunken comportment of the white pioneer, this novel social behavior required explanation. One readily available explanation, congruent with precontact cultural beliefs and values, was that the intoxicated person was inhabited by evil, supernatural agents. Since the drunk individual was thus "possessed", his actions while intoxicated were not his own and he was therefore not responsible for them. The tendency for the frontier white man to excuse drunken behavior among his peers only served to corroborate this mystical explanation. An indication of the continued effect of this early explanation was found by Levy and Kunitz (1974) insofar as a tendency was noted in tribes which valued magical power to be less condemning of drunken behavior and more ambivalent toward alcohol in general. The view that the intoxicated American Indian is not responsible for his behavior remains a formidable attitude among Indians today (Stratton, 1973).

Curley (1967) reported that Mescalero Apache do not consider persons who are intoxicated responsible for their behavior. Drunk persons are considered sufficiently bereft of their rational capacities so as to be regarded not aware
of their actions. This, of course, works in the favor of the individual alcohol abuser whose behavior, regardless of its nature, can be condoned under the rubric of intoxication. While there is usually some verbal disapproval of drunken comportment, legal sanctions beyond arrest and detoxification are rarely brought to bear upon the individual (Lemert, 1958). Therefore, as Brod (1975) points out, "When an intoxicated behavioral "excess" is tolerated, that drinking behavior is reinforced," (p. 1389).

Thus the attitude of non-responsibility for drunken behavior emerges as a fourth characteristic of American Indian alcohol abuse.

The next characteristic with which we will attempt to conceptualize American Indian drinking is more amorphous than those previously discussed and the route to its understanding is more circuitous. Nonetheless it seems sufficiently central to understanding the issue at hand to warrant inspection.

First it is necessary to recognize the extreme social and economic disruption which was consummated for western American Indians during the period from 1860 to 1890. Before that time most were hunting and gathering tribes living more or less autonomous existences on lands to which
they had multiple economic, social and spiritual ties. After that time tribes were militarily sequestered on lands which provided no buffalo, little game of other species, and were often marginally arable. Frequently these lands were of no historical or spiritual significance to the tribes, and were shared among tribes with no apparent relationship to each other (Dozier, 1966). In sum, social and economic organization which (depending upon the tribe) had developed over scores, perhaps hundreds of years, was severely disrupted in a period of 30 years, with little external assistance in reorganization. And all of this occurred fewer than 100 years ago.

There are at least two results of this disorganization upon alcohol use. First, reorganization might most naturally concern itself initially with survival issues: definition of authority and leadership, acquisition of reliable sources of food, shelter and eventually capital. Codification of culturally-specific behaviors such as drinking are likely secondary during social transition, and when such codifications occur, it will probably be coincident with either a relative lack of disruption or more quickly advanced reorganization. Levy and Kunitz (1974) observed that among those tribes most geographically isolated, and thereby least influenced by modern Anglo-American drinking practices, excessive drinking is the
modal behavior. Members of these tribes were also more
preoccupied with alcohol, suffered more from withdrawal
symptoms, were subject more frequently to social problems
resulting from alcohol abuse (arrest, accidents), but
suffered less from liver disease—indicating not an
increased incidence of alcoholism, but rather less social
sanction to restrict abusive use of alcohol. Devereaux
(1948) concludes that the absence of severe alcohol abuse
among the Mohave is due to their use of pre-contact social
sanctions to prohibit drunkenness and place alcohol use in an
adaptive social context. Cultural organization (or lack of
it) seems an important factor in controlling drinking
behavior, for individual personality characteristics as
tested by psychometric assessment have revealed no
distinguishing patterns of traits among American Indian
alcohol abusers (Kline, Royzynko, Flint & Roberts, 1973;
Westermeyer, 1972a), and personality differences between
American Indian & Anglo-American alcohol abusers appear to
be due not to neurotic or characterological pathologies, but
to cultural differences (Hoffman & Jackson, 1973).

Tribes in eastern Oklahoma which had developed
agricultural and business skills and maintained strong
tribal organization at the time of their forced placement on
reservations exhibit lower rates of alcohol-related problems
than do tribes in western Oklahoma which were less stable
economically and organizationally at the time of placement on reservations (Stratton, Zeiner & Paredes, 1978). The conclusion from all this seems to be that the extent to which the tribal organization was sufficiently stable to make the transition to Anglo-American acculturation, members of that tribe were capable of enforcing their own norm of moderate drinking now compatible with contemporary Anglo-American expectations. Conversely, the more severe was the nineteenth century tribal disruption, the more predominant will be the current excessive drinking behavior, modeled after nineteenth century whites (Levy & Kunitz, 1974).

It would seem reasonable, then, that the solution to American Indian alcohol abuse is acculturation. However, acculturation seems to promote as well as inhibit alcohol abuse. While acculturation may eventually promote non-abusive use of alcohol when it occurs on a large scale, the very process includes sufficient personal stress to elicit abusive drinking (Ablon, 1971). Dozier (1966) anecdotally describes instances in which social stress in specific tribal groups resulted in increased abusive drinking. Alternatively, Levy and Kunitz (1974) argue that excessive drinking is not a retreat from the ravages of social change for Navaho, but is rather a way of maintaining socially-valued experience in the face of acculturation.
Whatever the dynamics, it does seem to be the case that the processes of becoming "more like the white man" are capable of eliciting excessive drinking.

A fifth factor in our conceptualization of American Indian drinking can now be identified. Acculturation during the nineteenth century, in the form of enforced residence on reservations, was met by some tribal groups with sufficient economic and social resilience that they could control drinking practices on the strength of pre-existing values. For members of the tribes, moderate drinking was a culturally-valued behavior which in the twentieth century now matches Anglo-American expectations, thereby fostering continued acculturation. For other tribal groups, the nineteenth century was sufficiently devastating to leave only the frontier model of drinking as predominant. Although this model may now be in part maladaptive, insofar as it fails to meet the expectations of the white employer or social worker, it remains adaptive in another fashion as a way of coping with socially-induced stress and as a way of perpetuating social contacts as an Indian.

Much of the excessive drinking among American Indians takes place in small groups of 19 to 35 year old males (Dozier, 1966). It is sufficiently pervasive across individuals and tribes to be considered non-deviant within
the American Indian subculture (Levy & Kunitz, 1974), but rather can best be conceived of as a culture-specific way of maintaining social contacts, conviviality and perhaps a form of ceremonialism (Levy & Kunitz, 1974). It is the predominant mode of drinking both on and off the reservation (Ablon, 1971), and is perhaps the setting in which young American Indian males learn how to drink (Levy & Kunitz, 1974).

The social drinking group exerts tremendous pressure upon the individual to drink heavily and share his alcoholic and financial resources. This sharing may be conceptualized as an expression of traditional aboriginal communal life (Brod, 1975). It is the behavioral glue (Curley, 1967) which provides a commonality over several generations (Hoffman & Noem, 1975) and has been referred to as an expanded family because, "the Indian chronic alcohol abuser is surrounded by relatives and lifetime companions with whom normal relations are continued when he is drunk" (Vuttner & Lorincz, 1967). Social solidarity and a sense of communal well-being are thereby enhanced in the context of excessive drinking.

The opportunity to verbally express a commonly shared "Indian-ness" is provided by prolonged drinking parties (Brod, 1975). It should not be surprising, then, that
conversation within drinking groups frequently returns to former injustices at the hands of the white man concerning payment for tribal land, claims of descent from prominent tribe members, & General Custer's defeat (Kuttner & Lorincz, 1967). This cementing of cultural identity can also be accomplished by the retelling of stories and myths as well as the singing of drinking songs (Lemert, 1958).

Excessive drinking can also serve as an occasion for recounting former or beginning new exploits against the white man, a contemporary form of "counting coup", or simply for tales of bravery which occurred while driving intoxicated or hunting (Brod, 1975; Curley, 1967; Lemert, 1958).

Another regularly reported characteristic of these groups is the excessive pressure to drink at a pace equivalent to the rest of the group, (Levy & Kunitz, 1974). Lemert (1958, p. 93), observed, "each person must drink his share down, and to fail to drink would be an offense to the person giving the party, although to my knowledge this contingency has never arisen."

Ferguson (1968, p. 163) concurred in describing the Navaho.

The pressure to drink with friends is very great. Refusing to accept or buy a drink is an affront. The man who refuses is ridiculed,
pursued, or may have wine poured on his head. His relatives sometimes tell him he does not love them any more. Refusal under such circumstances is difficult.

A form of social pressure, more subtle than overt verbal coercion, has been demonstrated to affect drinking within groups in the laboratory. Caudill & Marlatt (1975) demonstrated that a confederate who drank heavily at a wine tasting party elicited more drinking from others present than did a light-drinking confederate or no confederate at all. Lied and Marlatt (In press) further demonstrated that persons with a history of heavy drinking were more influenced by the presence of a heavy drinking confederate than were persons with a history of light drinking. Garlington and De Ricco (In press) replicated these original results of Caudill and Marlatt in a simulated tavern with a reversal experimental design. Further, they demonstrated that with two simultaneous confederates, one drinking heavily and the other lightly, the subjects' drinking rate more closely approximated the heavy-drinking confederates' (De Ricco & Garlington, In press, a) and that disclosure of the confederates' experimental purpose did not change the subjects' drinking rate (De Ricco & Garlington, In press, b). Finally, when three confederates were introduced into the simulated tavern, two drinking heavily and one lightly, or the opposite, subjects' drinking rate approximated the rate of the majority of the confederates (De Ricco, 1978).
Reid (1977) was also able to affect the drinking rate of males in a small town tavern by introducing a heavy or light drinking confederate to the bar.

Thus a sixth characteristic in the conceptualization of American Indian alcohol abuse is apparent. American Indians, especially young males, consume a large proportion of their total alcohol consumption in the company of others, in a group which provides a rewarding social network for the individual while encouraging abusive drinking, both overtly through overt verbal encouragement and covertly, through modeling.

The behavior of this peer drinking group has been described by several observational studies (Curley, 1967; Ferguson, 1968; Kuttner & Lorincz, 1967; Lemert, 1958; Westermeyer, 1972a;b) and a summary of these observations aids in the appreciation of how the group functions. It is worth noting while reading the description, that many of the observations may not be unique to American Indian peer drinking groups.

Drinking is primarily a social function among five to ten adult males, usually from ages 20 to 45. Levy and Kunitz (1974) indicate that among the 58% of the Navaho who do not drink, one-half of them (29% of the total population) are former drinkers who, in middle age, became abstinent for
one reason or another. Females are frequently included in the group, but remain on the periphery. The drinking often takes place in a bar predominantly patronized by other American Indians, but the drinking can take place at the home of a host, out of doors or in an auto which is in transit from one drinking site to another. All of the drinking rarely takes place at one site, and the drinking group is quite mobile. Drinking group membership is loose and several members will join or leave as the drinking continues. All members are expected to contribute what is available to them in the way of money and liquor. Social pressure is exerted upon members to "keep up" or drink at a pace equivalent to the rest of the group, the implication being that the slower drinker is in some way failing to exhibit proper camaraderie. Beer is the beverage of choice, although bottles of wine are more convenient for drinking out of doors, and distilled liquor will be purchased if funds permit. Groups of younger males tend to be larger and more lively, while groups of older males tend to keep to themselves with more variable membership. The rate of consumption quickens or remains at a rapid steady rate as long as there is liquor and members are conscious. Slowing down or "taking a breather" is unheard of. Drinking continues until late Sunday night if drinkers are employed, or until funds are totally depleted or members have passed
out or have been arrested. There is no compunction to limit the drinking to a single day and drinking can frequently continue over a period of several days. It is in the advanced stages of intoxication that aggression against other persons or property can occur, as well as arrest or auto accidents. Any treatment modality aimed at effectively assisting American Indian alcohol abusers will need to address the peer drinking group directly.

Although there is some evidence that American Indians metabolize ethanol more rapidly than do Anglo-Americans (Reed, 1978), many alcohol counselors dispute the existence of a more severe reaction to alcohol among Indians (Robinson, 1974), while Levy and Kunitz (1974) found that incidence of liver disease and severity of withdrawal symptoms were not related to how much liquor was consumed within tribal groups. Physiological addiction and physical deterioration are not significant problems associated with alcohol abuse among Indians any more so than among other populations.

It is therefore not justifiable to consider all or most of American Indian alcohol abuse to be a physical dependence upon alcohol which results in definite medical symptoms. Leland (1976) carefully examined Jellinek's (1960) 44 diagnostic criteria for alcoholism and finds only three of
them to have sufficient, non-conflicting empirical verification of incidence among American Indian alcohol abusers as a group. Price (1975) contends that actual alcohol addiction is quite low among American Indians. Brod (1975) observes, "...it is no wonder that many thoughtful writers conspicuously avoid the label [alcoholism] while discussing heavy drinking problems," (p. 1387). It is therefore extremely tenuous to assert that the incidence of alcoholism as a single pathological entity is higher among American Indians than among a white population. Westermeyer (1972a) found alcoholism among the Chippewa to be significantly different from alcoholism among whites not on the basis of severity of symptoms or simple interracial variance but rather as it is related to unemployment and familial disintegration. Levy and Kunitz (1971) review the methodology of epidemiological studies of alcoholism among American Indian populations and conclude that a reliable base rate is currently unavailable. Sievers (1968) did not find overall rates of alcoholism among Arizona tribes to be different from that found in white Iowa populations. Heavy drinking, however, was found to be two to seven times greater. Frequency of drinking and intoxication rather than alcoholism as such appear to be the central problem.
A seventh factor in the conceptualization of American Indian drinking is thereby identified; it is not alcoholism as such which is the problem, but excessive use or abuse. There are many Indians who drink in an abusive fashion not because of some physiological or psychological pathology, but because their environments are so arranged, and their individual responses to the environment are currently constricted such that abusive drinking is the predictable behavioral outcome. This reformulation from the passive victim, incapable of managing his behavior implicit in the disease model of alcoholism, to an individual responding in a predictable fashion to dysfunctional environmental constraints (Levy & Kunitz, 1974) should be significant in the development of a treatment program.

It seems to be the multiple personal and social consequences of frequent and heavy alcohol abuse which so plague the American Indian. Stewart's (1964) data indicate that alcohol-related arrest rates among American Indian are twelve times greater than the national average and five times greater than that for blacks. Seventy-one per cent of these arrests were for public intoxication. Heavy alcohol use begins early among American Indians (Kline & Roberts, 1973; Indians Health Service, 1969), thus interfering early with education. Death attributable to physiological deterioration related to alcohol abuse is 4.5 to 5.5 times...
greater than the national average (Snake, 1976). Although
suicide rates for American Indians are no higher than for
the general population, violent death associated with
intoxication—suicide, homicide and auto accidents—in some
tribes is significantly higher than in the general
population (Price, 1975). Alcohol abuse does not cause
homicide and suicide, but the three are likely interrelated
to some other, more global cultural variables (Levy &
Kunitz, 1974). However, alcohol does seem to serve as a
releaser mechanism for relatively patterned, systematic
forms of aggression (Heath, 1964), very likely motivated by
pre-intoxication hostilities and frustrations. It is
hypothetically possible that alcohol serves as an excuse, not
a cause, for violence; that Indian males drink to express
aggression, rather than being made aggressive by drinking
(Levy & Kunitz, 1974). Finally, formal data are
unavailable, but many social workers and counselors in the
field can readily cite several instances in their immediate
experience wherein American Indian clients have lost jobs
and custody of their children due to immoderate drinking.

It is therefore the social, economic and familial
instability resulting from excessive drinking which cripples
the American Indian population. This constitutes the final
characteristic of Indian drinking to be defined in this
chapter.
Eight factors which are characteristic of American Indian drinking have been delineated to form a conceptualization of this problem.

1. American Indians learned to drink rapidly in order to avoid legal apprehension, and on two-thirds of the reservations they continue to do so for this reason.

2. Excessive drinking by Indians has usually been occasion for conflict with or exploitation by the white man during which the Indian either tried to wrest from or relinquished to the white man control for his own behavior.

3. Prolonged intoxication as well as drinking with intoxication as the primary goal by Indians is the result of frontier white modeling.

4. The American Indian, with assistance from the white man, views his own intoxicated behavior as behavior for which he cannot be held responsible.

5. Acculturation to white drinking norms of the nineteenth century, when resisted by some tribal groups, resulted in non-abusive drinking in this century. Acculturation acquiesced to by other tribal groups resulted in abusive drinking. Further acculturation within this second group may some day result in moderate drinking, but at present appears to maintain cultural stress sufficient to
elicit continued abusive drinking.

6. Much excessive drinking takes place in a peer drinking group which overtly and covertly reinforces alcohol abuse.

7. Alcoholism as a diagnosable pathology is no greater among Indians than among whites.

8. The social and personal consequences to alcohol abuse among Indians are central to the problem.
Treatment of American Indian Alcohol Abuse

Although $17.2 million in federal money is annually expended upon treatment for American Indian alcohol abusers (Snake, 1976), very little empirical evidence for treatment success has been established.

This is understandable, for whenever a treatment agency must make a choice in allocation of time and money between therapeutic effectiveness and data-gathering, the values of the agency will usually lead it to choose against more paper work.

Peter Miller (1978b, p. 145) characterizes the issue this way:

As with any treatment evaluation, these studies are not easy to conduct and are fraught with methodological, procedural and ethical problems that are often difficult to resolve. Conflicts between sound experimental methodology and the realities of dealing with individual patients in treatment often lead to compromises that eventually limit the value of the study.

Therefore the treatment regimen proposed in chapter 5 is designed to include treatment measures which also have therapeutic impact; yielding no loss in therapeutic effectiveness while providing treatment outcome measures more sensitive than the ones used in the three studies reviewed immediately below.
Ferguson (1970) reported on an 18 month community treatment program for Navaho based in McKinley County, New Mexico. During this time 111 Navaho males were treated with a five day detoxification hospitalization, disulfiram (Antabuse) administration, a lay contact person who monitored disulfiram usage, social work assistance & ad hoc counseling. The result was that 23% of the clients two years after treatment began were not involved in "destructive drinking" and had "strikingly improved...life situations," (p.909). During the treatment period clients' arrests for drunkenness were 22% of what they had been during the 18 months prior to treatment. Successful clients maintained this low level of arrests, while treatment failures' arrest records had climbed to 50% of the pre-treatment level. Correlates of treatment success were: poor mastery of the English language, age over 30, regular administration of disulfiram, and few relatives who were alcohol abusers.

Kline and Roberts (1973) reported on a residential treatment program for 135 urbanized American Indians living in northern California. The program had an inpatient setting at Mendocino State Hospital and ran for one year, although the average stay per client was two months. Therapy included American Indian nursing personnel, disulfiram administration, alcoholism education, cultural
education, and group and individual therapy. The authors note that large group meetings were unsuccessful, while small groups and individual therapy met with mixed results. Informal, ad hoc sessions seemed to them the most advantageous. No measure of treatment success was reported.

Shore and Von Fumetti (1972) evaluated three similar treatment programs in northeastern Utah, northern New Mexico and Nevada. The authors state that previous attempts at therapy with American Indians in these regions have failed because traditional medical treatment and sustained disulfiram use have not been broadly accepted among the American Indians, while Alcoholics Anonymous is perceived by American Indians as an unnecessarily embarrassing "confession" group where the revelation of intimate feelings is required for successful group membership. Instead, the three treatment programs described provide "family adjustment [counseling], vocational rehabilitation, education about alcohol and the involvement of youth," (p.135). Referrals were from the court and self-referrals. Of 642 clients treated by the three agencies combined during a four year period, 28% (180) were rated by staff as "significantly improved". No designated period of follow-up was reported and apparently criteria for rating varied widely across the three institutions. The success rate among women was higher than among men.
These three studies provide presumptive evidence to indicate that broad-based, long-term programs which benefit from community support are capable of eliciting non-abusive alcohol consumption at a rate higher than would naturally occur. They also raise the issues of: 1. the appropriateness of large group meetings of the sort A.A. traditionally uses and, 2. disulfiram administration for treatment of American Indian alcohol abusers. Traditional treatment of alcohol abuse usually has three components which may be used separately or in concert: hospitalization for detoxification, referral for counseling, perhaps to Alcoholics Anonymous, and disulfiram administration (Vaillant, 1978).

Regarding large, A.A.-type groups, Kline and Roberts (1973) as well as Shore and Von Fumetti (1972) found them inappropriate for use among Indians. Rudolph King, director of the large Inter-Tribal Alcoholism Treatment Center in Sheridan, Wyoming concurs by observing that the traditional A.A. format meets resistance from many Indians because, "Indians are often not inclined to speak freely of personal matters in front of a group," (Robinson, 1974, p.15). In addition, many tribes complain that group counseling does little to assist them in dealing with the drinking environment to which they must inevitably return (Snake, 1976).
Regarding disulfiram administration, Shore and Von Fummetti (1972) discredited it as inconsistent with Indian cultural values, while Ferguson (1970) found only 23% of her Indian clients capable of maintenance on disulfiram over a two-year period. Levy and Kunitz (1974) found that disulfiram did not keep self-identified Navaho alcohol-abusers from drinking, nor did maintenance on disulfiram predict less difficulty with the law.

The single bright prospect for integrating disulfiram treatment into traditional Indian culture is the finding by Ferguson (1970) that poor mastery of the English language was related to successful disulfiram maintenance. Nonetheless, impressive and extensive outcome data on chemical aversion therapy (disulfiram) were gathered by Lemere and his associates (1942; Cited in Miller, 1978a, pp. 196-197). At the end of thirteen years of follow-up, they reported 51% of their clients to be totally abstinent. There is no way of knowing, however, the extent to which these results are directly attributable to chemical aversion therapy and the extent to which they are also attributable to client selection and other non-specific factors (Miller, 1978a). Also, Lemere's population was totally Anglo-American, and may not generalize to American Indians.
In addition, the significance and clinical necessity of the treatment combination (A.A. groups and disulfiram) as the treatment of choice has recently been called into question (Pattison, Sobell & Sobell, 1978), along with the accompanying assumptions of such treatment: the mandatory nature of total abstinence as a treatment goal, the significance of "loss of control" drinking as a clinical phenomenon, and the "disease model" of alcoholism.

Alongside the specific problems noted above, there is a more general issue of treatment effectiveness using traditional therapeutic interventions. It is especially difficult to assess the significance of treatment outcome when, as Emrick (1975) observed, averaging over the 126 studies included in his review, among control group clients, "...13% of non-treated alcohol abusers were abstinent and 41% were somewhat improved, while 21% of minimally treated alcohol abusers were abstinent and 43% were somewhat improved" (p. 96). Of those who were treated, Emrick (1974) reports one-third were significantly improved, one-third were somewhat improved, less than one-third were unimproved, while about one-fifteenth were worse. Cahalan (1978) cites evidence to indicate that regardless of the treatment modality, 70% of the clients improve if they remain in treatment for 18 months, while far fewer improve if treatment is terminated prior to that, again, regardless
of modality. It should be noted that these data pertain exclusively to white treatment populations and efforts at traditional treatment of American Indian alcohol abusers have been notoriously less successful to date.

Little difference was found between various modes of treatment, and all modalities were found to be at least somewhat successful, causing Emrick to conclude (1975) that more time should be spent matching clients to therapy than developing new treatments.

Specificity of treatment modalities to peculiar needs of client populations has been related to treatment response (Smart, Schmidt & Hoss, 1968). The relationship between pre-existent client population characteristics and specificity of treatment has at least three implications (Pattison, Coe & Doerr, 1973): 1. if a client refers himself to a facility inappropriate for his SES or value system, he is less likely to respond favorably to treatment; 2. the most effective facilities are those with clearly defined target treatment populations; and, 3. no one facility is capable of effective "comprehensive" treatment of all populations. There is presumptive evidence, then, to postulate the need for a treatment modality more specifically targeted at American Indians and their cultures than traditional treatment has been.
In summary, past programmatic efforts at treatment for alcohol abuse among American Indians indicates that neither group counseling of the traditional A.A. type nor disulfiram therapy produce significant improvement, nor do they appear to be especially continuous with Indian cultural values and needs. Some programs have begun this effort, but continued attempts must be made to identify not only effective treatment for American Indian alcohol abusers, but also treatment attractive to them.

The treatment program proposed below is therefore not only designed with the primary goal of optimizing treatment outcome, it also has the secondary goal of providing treatment which is more-nearly tailored to the needs of the client population.
Cognitive/Behavior Treatment of Alcohol Abuse

Most behavioral techniques include with them the implicit assumption that total abstinence is not the only treatment goal for all alcohol abusers. This, of course is anathemous to a more traditional, Alcoholics Anonymous-oriented treatment approach and therefore deserves a modicum of attention at the outset.

A considerable amount of evidence has been accumulated from treatment-outcome studies (Pattison, et al., 1978) which indicates that a proportion of the clients in most abstinence-oriented treatments (5-25%) have engaged in non-abstinent, non-problem drinking for considerable periods of time following treatment. Perhaps the single most damaging piece of data to the mandatory nature of total abstinence as a sole treatment goal is to be found in the data of a study undertaken by Marlatt and his associates (Marlatt, Demming & Reid, 1973). Reasoning that the primary justification for mandatory abstinence is "loss of control" or the alcohol abuser's inability to control drinking after he has had a single drink, Marlatt gave 32 adult male alcohol abusers and 32 similar social drinkers either alcohol or tonic to drink ad lib while engaging in a "taste test." Half of them were informed of the actual nature of
the beverage they were drinking, the other half were falsely informed. Analyses indicated that although alcohol abusers drank more regardless of what they were told and what they were in fact drinking, the significant determinant was not whether their beverages were alcoholic or not, but whether they were told they were drinking alcohol or not. Thus, suggestion and not the chemical makeup of the beverage accounted for how much alcohol abusers drank. No evidence for loss of control drinking was present, and total abstinence as a sole treatment goal is thereby seriously questioned.

Orford (1973), in an analysis of the drinking patterns of 77 alcohol abusers not in treatment, identified 19 (25%) who were not abstinent and not drinking at problem levels for a period of over one year.

Nonetheless if successful alcohol abuser adjustment does not require total abstinence,

We ought to know a great deal more about who ought to enter on controlled drinking treatment—and who must not—than we now know...treatment aiming at controlled drinking can only be offered as a "treatment of last resort" to alcohol abusers who have exhausted all other treatment options. (Nathan, 1976).

Therefore, the program outlined below is designed to be compatible with both abstinence and controlled-drinking treatment goals, retaining the choice for the collective
judgement of client and therapist.

For some time behavioral clinicians have attempted to control drinking by pairing shock with alcohol ingestion. However, Miller, (1978a) has concluded in his review: 1. aversion to drinking does not occur as a result to electrical aversion therapy, and 2. the effects of the treatment are more related to placebo effects and therapeutic expectancy than to conditioning.

Several attempts have been made, particularly in an inpatient treatment setting, to manipulate the amount and rate of drinking among alcohol abusers by direct experimental control of environmental reinforcers.

Videotape review of previously recorded drunken comportment does not affect the frequency of drinking or the frequency of sobriety in chronic alcohol abusers, while it does tend to elicit a higher attrition rate from therapy (Schaefer, Sobell & Mills, 1971b). In addition, the apparent lack of social opprobrium and embarrassment over drunken comportment among American Indians argues that this would be an inappropriate treatment modality for them.

Contingent reinforcement of 0.00 blood alcohol concentration (BAC) with a $3.00 canteen booklet can modify rate of alcohol consumption among inpatients for brief
periods of time (Miller, Hersen, Eisler & Watts, 1974). Similar results have been obtained with 13 of 20 heroin abusers (Boudin, 1977). Permission for visits outside of the hospital (Cohen, Liebson, Faillace & Allen, 1971), money (Bigelow, Liebson & Griffiths, 1974) and access to an enriched ward environment (Griffiths, Bigelow & Liebson, 1977) when granted contingent upon sobriety, have all been demonstrated to affect frequency of drinking among alcohol abuser inpatients.

Murray & Hobbs (1977) were able to maintain a lowered rate of alcohol consumption in a married couple for over one year using a seven week self-imposed time-out procedure after each drink. With this single exception, these control-of-reinforcement treatments are largely limited in their application to inpatient settings, and their efficacy has as yet to be reliably demonstrated in controlling drinking behavior after release from the inpatient facility.

After self-administrations of alcohol with regular corrective feedback given to estimations made during training trials, individuals can be trained to accurately estimate (and thereby presumably control) their BAC on the basis of interoceptive cues, (Huber, Karlin & Nathan, 1976). There is question, however, whether alcohol abusers can be similarly trained to estimate (and thereby presumably
control) their BAC (Ludwig, Bendfeldt, Wikler & Cain, 1978; Ewing, 1975) or whether other treatment components are necessary to maintain the effectiveness of such a treatment when chronic alcohol abusers are the clients (Caddy & Lovibond, 1976; Silverstein, Nathan & Taylor, 1974).

Forcing the client to make structured, regularly scheduled drinking decisions whether to drink or abstain, over a period of weeks can enhance treatment outcome whether the decision is made individually (Gottheil, Crawford & Corneilson, 1973; Thornton, Gottheil, Gellens & Alterman, 1977) or in a group (Goldman, Taylor, Caruth & Nathan, 1973).

For each of these demonstrations that personal control of the antecedents or consequences of an alcohol abuser's drinking modifies the frequency of drinking, the methods have been confined to laboratory or inpatient settings and have as yet to demonstrably control drinking over several months in an outpatient setting.

Self-monitoring is usually used as a part of a larger treatment regimen (van A Sobell & Sobell, 1978). It is generally accepted that observation of behavior changes the behavior. Self-monitoring alone can modify the frequency of addictive behavior (McFall & Hammen, 1971), perhaps because it interrupts the chain of consummatory behavior (Bellack,
Rozensky & Schwartz, 1974). Records of drinking frequency also provide relatively accurate information both for the therapist and the client as to how well treatment is progressing. Although the accuracy of all self-rating is lowered by a generalized desirability response set as well as the regularity and the contingency upon the measured behavior with which the recording takes place, alcohol abusers as a group tend to be quite accurate in their self-reports (Sobell & Sobell, 1975; Summers, 1970). Finally, when the record includes such data as the place, time, others present and type of drink, this information can be utilized in stimulus control training.

Stimulus control training involves making the client aware of the environmental conditions which characteristically elicit problem drinking. The salient information can be gathered from Drinking Profiles (Marlatt, 1976a), or from the self-monitoring reports. Caddy & Lovibond (1976) found that such training was the effective component when paired with aversion control training. W. M. Miller (1978) found it to be the effective treatment component when paired with BAC discrimination training. Kennedy, Gilbert & Thoreson (1978) found stimulus control training aided in maintenance of abstinence for ten male alcohol abusers although their follow-up period was only one month after treatment. In a case history (Hodgeson & Rankin, 1978) maintenance of
controlled drinking was found for over six months after treatment when the single client was trained to control interoceptive cues accompanying an initial drink.

Rate-reduction training involves teaching the client to drink less. Research on the normal drinking rates of alcohol abusers and non-alcoholics revealed that alcohol abusers take fewer sips per drink (i.e., larger sips), drink straight alcohol more frequently (Schaefer, Sobell & Mills, 1971a), drink more per hour & increase sip size over time (Sobell, Schaefer & Mills, 1972; Williams & Brown, 1974). Training alcohol abusers to take smaller sips and sip more slowly on weaker drinks with aversive conditioning resulted in abstinence six weeks later in over one-third of the clients trained (Mills, Sobell & Schaefer, 1971). However, training components appear to be negatively reactive (Miller, Becker, Foy & Wooten, 1976), viz., when clients are trained to sip more slowly, they take larger sips. Also, there is evidence that the rate of drinking by those present serves as a potent modeling force influencing rate of drinking (Caudill & Marlatt, 1975), thereby rendering rate-control training alone in a laboratory difficult to generalize to a barroom situation where others are drinking at non-trained rates.
Relaxation training can be therapeutically utilized as a behavioral alternative to drinking. Experimentally-induced stress does not by itself increase the rate of drinking (Higgins & Marlatt, 1973). Also, it appears unlikely that alcohol actually reduces anxiety after the first few drinks (Marlatt, 1976a), and the stress-reduction explanation of abusive drinking is largely inadequate to explain why a person drinks to the point of intoxication (Capell & Herman, 1972). Thus it seems that subjective stress does not automatically elicit alcohol abuse and abusive drinking is an inadequate strategy for coping with anxiety. Nonetheless, social stress and frequency of drinking do seem to be in some way related (O'Leary, O'Leary & Donovan, 1976), and people talk as if they drink to relax. Perhaps, then, self-induced relaxation can provide an adaptive substitute for what is perceived by abusers as alcohol-induced relaxation, and as a remedy to behavioral deficits which make relaxation without alcohol difficult.

Relaxation techniques which are trained as replacements for drinking have been shown to modify the client's mood (Gilbert, Parker & Claiborn, 1978), decrease alcohol consumption in heavy drinkers over a six week period (Marlatt, 1976), as well as aid other treatment components in the maintenance of abstinence (Kraft & Al-Issa, 1968) and
controlled drinking (Hedberg & Campbell, 1974).

Social skills training with alcohol abusers is another method of reducing socially-induced stress. The individual who wants to say or do a particular thing, but finds himself unable to because of a behavioral deficit, can become quite frustrated and find himself in a very stressful situation (Rimm & Masters, 1974). Three specific deficits have been identified in alcohol abusers: the inability to refuse a drink, the more general inability to express negative assertiveness (saying "no", setting limits on others' behavior) and the inability to express anger (Miller & Eisler, 1977).

A group of clinicians in Mississippi (Foy, Miller, Eisler & O'Toole, 1976) have developed a limited treatment program which trains alcohol abusers to effectively refuse drinks. The excessive difficulty an American Indian may face while trying to refuse a drink from his peer, suggests that this is an ideal treatment modality for them.

Marlatt and his associates have found that among many heavy social drinkers, provocation to anger with no opportunity to retaliate elicited heavier drinking than did provocation with the opportunity to retaliate or no provocation at all (Marlatt, Kosturn & Lang, 1975), while being told one had consumed alcohol, whether in fact the
beverage consumed was alcohol or tonic water, also elicited more retaliation to provocation than did being told one had consumed tonic water (Lang, Goeckner, Adesso & Marlatt, 1975). Alcoholics have been found to judge themselves as more assertive than others judge them to be and have been found to lack skills in negative assertiveness (Miller & Eisler, 1977). The evidence indicates that generally the alcohol abuser's expressiveness increases with the amount of alcohol he has had, (O'Leary, O'Leary & Donovan, 1976). Therefore, the cumulative evidence suggests that alcohol can be abused in the presence of unexpressed anger to facilitate eventual expression of negative affect.

Despite the exploratory nature of research into social skills training for alcohol abusers to date, and despite some methodological difficulties, the techniques appear to be useful in enhancing interpersonal performance of alcohol abusers (Van Hasselt, Hersen & Milliones, 1978).

It seems, then, that aversion treatment, manipulation of environmental variables, BAC discrimination training and drink decision-making treatment are inappropriate for a generalized outpatient treatment setting. Self-monitoring, stimulus-control training, rate-reduction training, relaxation training and social skills training seem potentially useful.
Covert techniques are nothing new to the repertoire of the behavior therapist (Cautela, 1966), but they are relatively untried with alcohol abusers. The techniques involve the client, while in a relaxed state, in imagining a scene as it is described by the therapist. The scene can be depicted to include any number of reinforcement paradigms.

Cautela (1970) described the pairing of noxious scenes along with the presentation of alcohol in a negative reinforcement paradigm he called covert sensitization. Ashen and Donner (1968) found this technique to sustain abstinence in six of 15 clients six months after treatment. Cautela and Upper (1975) described a technique they call "covert reinforcement", during which the client imagines himself to be drinking in an adaptive fashion and then rewards himself with a pleasant, relaxing scene. This is similar to a technique elsewhere called "covert modeling" (Hay, Hay & Nelson, 1977) in which one client was taught to imagine himself adaptively dealing with a potentially uncontrolled drinking situation. Six repetitions of five such scenes over a three week period resulted in abstinence over an eleven month period. Gotestam and Melin (1974) used a procedure they labelled "covert extinction" with four female amphetamine abusers. They received over 100 imaginal pairings of a "shooting up" scene with a consequent scene describing lack of euphoria or physical reaction to the
drug.

In addition, Rychtarik and Wollersheim (In Press) suggest that the alcohol abuser views himself as a morally worthless person and a failure. Snyder (1975) also points out that the alcohol abuser's self-image is chaotic, unrealistic and severely recriminatory. Both suggest that cognitive restructuring can serve to alter these self-views and covert self-instruction seems an ideal way of doing so (Miller & Munoz, 1976). With this technique, the client imagines a problematic scene, responds to it in a previously learned adaptive fashion, and then rewards himself with a statement affirming his self-worth and ability to control situations.

Results from covert techniques are equivocal, however. Anant (1968) found that long term follow-up of clients treated with covert sensitization only, reduced to 20% a much higher success rate found earlier over a shorter interval. Wilson and Tracey (1976) were unable to suppress alcohol consumption with covert sensitization only, in a controlled laboratory setting. Therefore, the results of covert techniques in moderating alcohol abuse to date are mixed and generally modest, and have as yet to reliably demonstrate clinically significant therapeutic results (Mahoney, 1974). Nonetheless, the current limited
verification of effectiveness does not preclude their inclusion in a multi-modal treatment package.

Multi-modal therapies, although less precise in their ability to demonstrate treatment-response causal relationships, seem to be the most promising in eliciting long term change in drinking patterns. This is likely because alcohol abuse is a multiply-caused, multiply maintained syndrome, requiring several treatment modalities to effect significant change.

Hamburg (1975) in his review of the literature through 1974 concludes that broad-spectrum treatment approaches have provided the best evidence of effective therapeutic change to date. Marlatt & Gordon (1978) urge the continued exploration of various treatment components which can as a composite program avoid the antecedents and ameliorate the causal agents of relapse.

Azrin (Hunt & Azrin, 1973; Azrin, 1976) has developed a "community reinforcement approach" to the treatment of alcohol abuse. They provide job and family counseling, recreational and social facilities, group counseling, daily reporting to counselors and incentives from the alcohol abusers' social community to remain sober. The results of this broad-band treatment approach, over a two year period, are significant differences between treatment groups and
matched control groups in time institutionalized (jail and hospital), time living at home, time employed and number of sober days.

Individualized behavior therapy (Sobell & Sobell, 1973; 1976a; 1978) includes alcohol education, self-control training, self-monitoring and intensive follow-up over two years. Results two years later indicate clients remained abstinent or drinking at controlled levels 85% of the time.

While the program proposed in Chapter 5 will not have the duration of either community reinforcement or individualized behavior therapy, it is designed to be equally broad and inclusive. It seems likely, then, that covert rehearsal and reinforcement, combined with behavior treatment in a multi-modal treatment package can be an effective treatment alternative for American Indian alcohol abusers, regardless whether the treatment goal is abstinence or controlled drinking.
A Rationale for Cognitive/Behavior Treatment of Alcohol Abuse
Among American Indians

The need for a culture-specific treatment for alcohol abuse among American Indians is an attractive commonsense notion. Dozier (1966) concluded that traditional

...techniques of treatment are designed for alcoholics of the dominant society and take little or no consideration of the specific social and cultural backgrounds of Indians...psychotherapeutic methods, unless modified to consider the cultural and social deprivations suffered by Indians, will continue to be unsuccessful. (pp. 82-83).

Bert Eder, chief of the Indian desk at NIAAA agrees. "We can't hope a program will succeed unless Indian sociocultural expectations are taken into account," (Robinson, 1974, p. 13).

Finally, a recent survey of treatment needs among Montana Indians concluded, "Alcoholism treatment for Montana Indian people...should be centered on cultural distinctions" (Grimes, 1978, p. 42).

However, it is perilous to simply group all American Indians together and glibly speak about their "culture and values." Vine Deloria pointedly states,

For most of the century it has been necessary for people of different tribes to keep reminding non-Indians that all tribes are different, that
they will have different histories, different languages, different cultural values and different religions (1973, p. 54).

Kuttner and Lorincz (1967), after comparing several American Indian cultures and drinking patterns, conclude, "...each tribe assimilates alcohol into its culture according to a pre-existing set of circumstances specific to each group," (p.537). Therefore a sweeping generalization or vast categorization carries with it low inferential power.

Most tribes were introduced to alcohol in the early eighteenth century through trade with white men (Stevens, 1959; Turner-High, 1959), and use continued more or less unimpeded by the Indian Intercourse Act of 1832. Approximately one-third of the reservations have legalized alcohol between 1954 and the present (May, 1976), while two-thirds still have not.

There is then some general uniformity between tribal groups in their histories of alcohol acquisition and use. Any particular program, however, will need to seriously consider specific cultural idiosyncrasies within the tribal group for whom that treatment is being planned.

The pragmatism of behavioral science should not be superficially wed to the more mystical nature of American Indian culture. Expedient and opportunistic imposition of
white culture upon American Indians has been noted and resisted throughout the history of Western America. An eighteenth century Cherokee chief, Old Tassel, noted,

Much has been said of the want of what you term "civilization" among the Indians. Many proposals have been made to us to adopt your laws, your religion, your manner and your customs. We do not see the propriety of such a reformation. We should be better pleased with beholding the good effects of your doctrines in your own practices than with hearing you talk about them. (Andrist, 1964, p. 30).

What seems necessary is a sympathetic appreciation and willingness to incorporate some of the less empirical, more ethereal aspects of Indian culture into behavioral science in order to effect a more potent treatment. The assumption of therapeutic effectiveness in such an approach should not be lightly dismissed as primitive sympathetic magic in a day when subliminal stimulation (Silverman, 1976), treatment expectancy effects (Wilkins, 1977), and experimenter bias (Rosenthal, 1966) are considered significant psychological phenomena to be accounted for in experimental design.

Indigenous alcohol counselors may refer to this quality as "spirituality" (Robinson, 1974, p.13), for it is a popularly held opinion that "...the Indian cultures, historically, have had difficulty in developing strong social controls for the usage of alcohol when not used in a spiritual context," (Snake, 1976, p.24). Several nativistic
movements suggest the tenability of such an opinion.

The Iroquois prophet Handsome Lake, on the authority of his visions, preached that alcohol was the work of the devil and thereby initiated near-universal temperance among the Iroquois in the early nineteenth century (Carpenter, 1959). Wovoka, a Paiute prophet, also on the basis of his visions and preaching, initiated a groundswell popular movement which eventuated into the Ghost Dance movement and included temperance as a fundamental tenet among the western tribes in the late 1880's (Brown, 1970). Currently, the Native American Indian Church is quite successful in maintaining abstinence among its members (Dozier, 1966).

Recurrent in American Indian religious literature is the "vision quest" (Brown, 1953, 1964; Deloria, 1973, p. 259), in which the individual absents himself from society for a period of time for the purpose of reflection in order to gain insight, a message or a vision. Such meditational practices can be initiated for the modern American Indian who is having difficulty with alcohol abuse by using covert cognitive techniques (Benson, 1974; Marlatt, 1976c; Shafii, Lively & Jaffe, 1975).

Symbols such as the encircled cross and the number 7 hold cosmological significance (Brown, 1964; Tedlock & Tedlock, 1975). Particular flora are revered as having
medicinal properties (Deloria, 1973; Tedlock & Tedlock, 1975) as do several sacred objects peculiar to each tribe (Tedlock & Tedlock, 1975). Such iconography can be reproduced on forms, manuals or any papers given to alcohol abuse clients.

Another salient American Indian cultural value is an intrinsic, mystical-religious attachment to the land (Deloria, 1973), especially particular geographic points (mountains, streams) which are considered sacred and thereby provide both power and good medicine for the tribe. Deloria (1973) observed, "American Indians hold their lands -- places -- as having the highest possible meaning, and all their statements are made with this reference point in mind" (p. 75). A related salient American Indian characteristic is the perception of man and the natural environment as co-existing in "... a continuous stream of life" (Deloria, 1973, p. 108), or as a continuous circle (Neihardt, 1961, p. 200). This might best be conceived of by non-Indian minds as an all-consuming ecological concern with additional ethical and mystical implications.

This attachment to and respect for the land can be used as a positive reinforcement in covert techniques, instating an image of particular geographic locations as a reinforcer for imagined, appropriate social behavior. If the location
is not distant from the treatment center, it could also be used as the actual site of some sessions using covert techniques.

However, much of this cultural heritage is lost to the contemporary American Indian. Separated from sacred places, without access to practicing medicine men (Deloria, 1973), many urban-dwelling American Indians recall these things only dimly as stories once told by parents or grandparents. This separation can be conceived of as an infrequent or irregular presence of extremely salient and powerfully reinforcing environmental stimuli capable of eliciting culture-specific, positively reinforcing cognitions.

A treatment program designed to be effective with American Indian alcohol abusers will then regularly present such cultural stimulation paired with treatment components in the attempt to associate non-abusive drinking and positively reinforcing cognitions regarding "Indianess" in the mind of the client. Two effects of such an approach may be anticipated: 1. the client may view treatment more favorably because it is associated with a culture he personally values, and 2. the client will find it more difficult to think of abusive drinking as a characteristically Indian behavior. Thus attitudes and values about drinking as well as drinking behavior are being
modified (Cahalan, 1978).

Deloria (1973) puts it succinctly: "A way must be found to reinterpret tribal cultures in terms of how they support, parallel or oppose knowledge of the world now available," (p. 268).

In addition to utilizing Indian cultural values to therapeutic advantage, a cognitive/behavior treatment program can be used as an attempt to address eight factors which are characteristic of American Indian drinking.

1. American Indians learned to drink rapidly in order to avoid legal apprehension, and on two-thirds of the reservations they continue to do so for this reason. A cognitive/behavior treatment program can provide experience and instruction in drinking at rates which are less likely to result in abusive drinking. In addition, self-monitoring techniques are capable of eliciting awareness of the frequency and rate at which the client is drinking. Although the threat of legal apprehension remains intact, the behavioral deficit caused by it—drinking at moderate rates—is addressed.

2. Excessive drinking by Indians has usually been an occasion for conflict with the white man or exploitation by him. In cognitive/behavior treatment the client is made
aware of environmental antecedents to abusive drinking, and is provided with social and relaxational skills to deal with interracial stress and conflict which may otherwise predicate abusive drinking. The program has self-control as a central treatment goal. As such, cognitive/behavior treatment is both in philosophy and content a redress to subordination to white values.

3. Prolonged intoxication and drinking with intoxication as a primary goal by Indians is a result of frontier Anglo-American modeling. Cognitive/behavior treatment provides the Indian with an alternative, more adaptive model in the form of moderate drinking. Further, in treatment designed specifically for Indians, abusive drinking is identified as something quite apart from traditional Indian culture and values, if not behavior (Grimes, 1978). It implicitly identifies abusive drinking as "non-Indian." As such, it takes part in a more general cultural transition taking place on reservations, motivated primarily by American Indian paraprofessionals who are gradually redefining what is appropriate Indian behavior (Levy & Kunitz, 1976), and thereby providing another component to the evolution of popular attitudes and values which are primary to control of alcohol abuse (Cahalan, 1978).
4. The American Indian, with support from the white community, views his own intoxicated behavior as behavior for which he cannot be held responsible. This "myth of uncontrol" is directly countered by training in self-monitoring, manipulation of one's own social environment, and social skills training at using social situations for the maintenance of control rather than blithely allowing social situations to control drinking rate.

5. Acculturation appears at present to maintain cultural stress sufficient to elicit continued abusive drinking in some tribal groups. Stress-coping skills are taught. Cognitive/behavior treatment involves the client using both overt verbal behavior and covert imagined behavior to address situations assertively. It also provides relaxation training to take the place of intoxication as a reduction of stress.

6. Much excessive drinking takes place in a peer drinking group which overtly and covertly reinforces alcohol abuse. Cognitive/behavior treatment provides stimulus control training which enables the client to recognize quickly a social situation which is likely to involve him in abusive drinking, while training social skills capable of thwarting overt social pressure.
7. Alcoholism as a diagnosable pathology does not appear to be greater among Indians than among whites. Alcohol abuse rather than alcoholism as such is treated by cognitive/behavior therapy, alleviating the prerequisite "passive patient" role in a disease conceptualization of alcoholism.

8. The social and personal consequences in alcohol abuse are central to the problem. To the extent that cognitive/behavior treatment can decrease alcohol abuse, it will reduce the incidence of its consequences. In addition, covert cognitive techniques can use imaginal positive, functional consequences to non-abuse as a reinforcer of appropriate social behavior.

Because life-long abstinence is a low-frequency behavior among many tribal groups, either naturally, or as treatment outcome (Brod, 1975; Curley, 1967; Westermeyer, 1972b), American Indians appear to be an appropriate population for controlled drinking treatments, either to directly train controlled drinking, or as a relapse prevention therapy in abstinence-oriented treatment.

Evidence of the flexibility of cognitive/behavior treatment resides in its ability to be used to support either the more traditional abstinence-oriented therapies of Alcoholics Anonymous and disulfiram prescription or the more
recent controlled-drinking behavior therapies. In the former treatments this program can provide skills which reinforce abstinence and make it more probable, while providing coping skills which enable rapid and only moderately injurious recovery after relapse has occurred (Marlatt & Gordon, 1978). In the latter treatment, this program serves to monitor and modulate the level of controlled drinking.

In either case, this program need not be accepted or rejected as feasible on the basis of the reader's abstinence vs. controlled-drinking biases and the extent to which s/he sees this program accommodating those biases. A furor is growing over the extent to which controlled-drinking is a legitimate treatment goal (Pattison, Sobell & Sobell, 1977), which will be calmed only when empirical evidence is produced indicating for which persons it is a legitimate goal and for which persons it is not (Nathan, 1976). Until that time, evidence does exist that multi-modal cognitive/behavior treatments are successful in maintaining either abstinence or controlled drinking (Sobell & Sobell, 1978). Also, until that time and doubtless long after, counselors will continue to prefer one or the other of the goals on the basis of experience.
This program does not force a choice between the two treatment goals. It facilitates either. It does assist the client, however, in making a clear choice between either of those goals on the one hand and the "goal" of uncontrolled drinking on the other.

In summary, the treatment described in Chapter 5 is designed to meet the specific needs of a subpopulation of alcoholics, using preexisting cultural values to reinforce cognitive/behavior treatment goals. It is possible that such a blend of cultural heritage, individual need and established therapeutic procedure may not only benefit individual clients and add another treatment to the therapist's armamentarium, it could also potentially assist communities in the redefinition of their own cultural and historical significance.
A TREATMENT PROGRAM

This booklet is designed to help you conduct therapy. The treatment is broken down into one pre-treatment assessment, 19 treatment segments (numbered 2-1 through 8-1) and one post-treatment assessment. Follow-up contacts are also scheduled. The progression of treatment with any given client will probably not be so orderly that one treatment segment will equal one therapy session, but it is important that regardless of how treatment progresses, each session should begin with: 1. review of Alcohol Intake Sheets (AIS's) completed since the last session, 2. hand out new AIS forms, and 3. take a MOBAT reading. In addition, each set of three treatment sessions is designed as a block (e.g., 3-1, 3-2, and 3-3). In the first, AIS forms are closely scrutinized for evidence of progress and material for discussion with the client. In the second, AIS forms are reviewed for problems with the new skill learned during the previous block of three sessions, and in the third, a new skill is trained. Attention should be paid to this progression of treatment, even if it is conducted on a different schedule, for it assures that new skills are generalized to actual occurrences indicated by the AIS form.
Here is a schedule of treatment:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Treatment</td>
<td>Introductions</td>
</tr>
<tr>
<td></td>
<td>Administer Marlatt Drinking Profile</td>
</tr>
<tr>
<td></td>
<td>Demonstrate M0BAT and explain</td>
</tr>
<tr>
<td></td>
<td>Demonstrate AIS, hand out</td>
</tr>
<tr>
<td>2</td>
<td>Collect M0BAT. Collect AIS</td>
</tr>
<tr>
<td></td>
<td>Hand out more</td>
</tr>
<tr>
<td></td>
<td>Limit-setting decision</td>
</tr>
<tr>
<td>2</td>
<td>Explain fully AIS</td>
</tr>
<tr>
<td>2</td>
<td>Go over last week's AIS for problems</td>
</tr>
<tr>
<td>3</td>
<td>Collect M0BAT. Collect AISs, hand out more</td>
</tr>
<tr>
<td></td>
<td>Discuss AIS in terms of limit setting</td>
</tr>
<tr>
<td>3</td>
<td>Stimulus control exercise</td>
</tr>
<tr>
<td></td>
<td>Rate instruction</td>
</tr>
<tr>
<td>3</td>
<td>Directed cultural discussion</td>
</tr>
<tr>
<td>4</td>
<td>Collect AIS, hand out more</td>
</tr>
<tr>
<td>4</td>
<td>Go over AIS for recording problems</td>
</tr>
<tr>
<td>4</td>
<td>Discuss AIS in terms of stimulus control and rate instruction</td>
</tr>
<tr>
<td>4</td>
<td>Social skills training</td>
</tr>
<tr>
<td>5</td>
<td>Collect M0BAT. Collect AIS, hand out more</td>
</tr>
<tr>
<td></td>
<td>Discuss results of AIS</td>
</tr>
</tbody>
</table>
5.2 Discuss AIS in terms of social skills
5.3 Relaxation training
6.1 Collect MOBAT. Collect AIS, hand out more
   Discuss results of AIS
6.2 Discuss AIS in terms of relaxation as an alternative
6.3 Covert rehearsal
7.1 Collect MOBAT. Collect AIS, hand out more
   Discuss results of AIS
7.2 Discuss AIS in terms of covert rehearsal
7.3 Covert reinforcement
8.1 Collect MOBAT. Collect AIS
   Discuss AIS in terms of covert reinforcement
   Collect AIS
Post-
   Administer Marlatt Drinking Profile Treatment
   Hand-out treatment summary card from pre-treatment Marlatt
Pretreatment

Introductions.

1. Introduce yourself, where you come from, what you want out of life, etc.

2. Ask clients to do same.

3. Introduce treatment task:
   a. Rationale for all the testing
      i. Aids treatment in getting to know more about client
      ii. Aids program by verifying how well clients did.
   b. Experimental nature of the program—
      i. what it can do for treatment program.
      ii. what it can do for them
   c. Rationale regarding drinking:
      i. Best goal is abstinence—simplest to obtain in the long run, so many of you will shoot for that.
      ii. However, failure to maintain abstinence is not failure in this program. It's a partial success.
      So we'll be working with you to avoid drinking, and when you don't, we'll work with you to find out why.
      iii. Also, we're very interested in partial successes. If you ordinarily drink 10 of 30 days, and we can get you to 5 of 30, and keep it there -- that's 1/2 the problem solved.
**d. Rationale for MOBAT**

Breathing into this balloon each time you come in here may at first be awkward and embarrassing for you. We're really very sorry about this. But as we explained earlier, this is an experimental program and we need proof that it is working in order to continue to get money in order to do it. So you're doing us a very big favor by using the balloon and we appreciate you doing it very much.

Also, once in a while, especially at first, some of you may come in with alcohol on your breath. That doesn't mean that the treatment isn't working. If you are drinking before you come in that's yours and your counselor's business only, and nobody else needs to know. We aren't going to scold you or make you feel guilty if you have been drinking. We simply want to know how you're doing. OK? Any questions on that?

4. Introduce MOBAT—explain its function, how we'll use it, demonstrate. Collect first sample.

5. Introduce Marlatt Drinking Profile. READ ALOUD TO THEM. About 75 choice or fill-in-the-blank questions about alcohol habits and preferences. Should take about an hour. If any difficulties, understanding questions, ask a therapist.

**NOTE:** This questionnaire is long and can be tedious. It could disrupt rapport and relationship early in the treatment. It is possible to administer it orally and record the responses. This of course takes more staff time. However, an
oral presentation also ameliorates any language difficulties a client may have. The therapist should use his judgement.

6. Introduce AIS:
   a. Daily--go thru column by column.
   b. Demonstrate using a past day of your drinking as an example.
   c. Answer questions.
   d. Have them do two for the last two days.

7. Reliability Enhancement Package
We have reason to believe that you are honest in evaluating your own performance and have a high degree of personal integrity. Because the information you will be giving us tends to be extremely accurate and truthful, any modifications in the treatment program we may later make are apt to be a direct reflection of the data you report. Therefore, if you inaccurately report how you are doing, it may result in a significant waste of time, money, and energy for us all. If you give us inaccurate information we could possibly change the program for other people in the future in a way which is inefficient or even harmful to them. Therefore, anything other than honest reporting could hurt other people we later treat.

MAKE ARRANGEMENTS FOR NEXT MEETINGS
NOTE: The therapist should become very familiar with each client's Marlatt Drinking Profile between this time and
2-1

1. Collect AIS, hand out more

2. a. Collect Mobat.

   b. *Rationale for MORAT (Repeated)*

Breathing into this balloon each time you come in here may at first be awkward and embarrassing for you. We’re really very sorry about this. But as we explained earlier, this is an experimental program and we need proof that it is working in order to continue to get money in order to do it. So you’re doing us a very big favor by using the balloon and we appreciate you doing it very much.

Also, once in a while, especially at first, some of you may come in with alcohol on your breath. That doesn’t mean that the treatment isn’t working. If you are drinking before you come in that’s yours and your counselor’s business only, and nobody else needs to know. We aren’t going to scold you or make you feel guilty if you have been drinking. We simply want to know how you’re doing. OK? Any questions on that?

*NOTE: At this time it would be appropriate to involve a recognized spiritual leader from the community or reservation to discuss traditional values and their place in one’s life. Comment would also be appropriate at this point on the non-traditional nature of intoxication.*

3. *Limit-setting*.
a. Abstinence is the safest and easiest goal for someone to attain when he is trying to control his drinking. However, few people stick to that goal throughout their lifetime. And when they fail to maintain abstinence, they often end up feeling guilty, bad about themselves and like failures—feelings which often start them drinking even more! Therefore, it seems wise for at least some of you to set a limit on your drinking, a number of drinks over which you know that your’re drinking too much, but under which you know you’re not abstinent and also know that you’re in control but have to continue to watch how much you drink very closely. So, if we’re going to set such a limit, and do so for our own good, we have to know some other things first.

b. The amount of alcohol in your body when you drink is measured by a proportion between the blood and alcohol in your system. This is called the Blood Alcohol Concentration, or simply, BAC. BAC is measured in mg%, just like length is measured in inches or feet. Mg% can range from 000 (no alcohol in body) to 450 (dead). If you’ve ever had a breathalyzer test done at the Police station, they were measuring BAC. Let’s look at different levels of BAC and see how they effect you. (From Miller & Munoz, 1976, p.11).

At 20 mg% light and moderate drinkers begin to feel some effects. This is the approximate BAC reached after
one drink.

At 40 mg% most people begin to feel relaxed.

At 60 mg% judgement is somewhat impaired; people are less able to make rational decisions about their abilities (e.g. to drive).

At 80 mg% there is a definite impairment of muscle coordination and driving skills; legally drunk in some states.

At 100 mg% there is clear deterioration of reaction time and control; legally drunk in most states.

At 120 mg% vomiting occurs, unless this level is reached gradually.

At 150 mg% balance and movement are impaired. This BAC level means that the equivalent of one-half pint of whiskey is circulating in the bloodstream.

At 300 mg% many people lose consciousness.

At 400 mg% most people lose consciousness; some die.

At 450 mg% breathing stops; death.

c. That's how different levels of alcohol in your blood can effect you. If you're going to drink, what sounds like a safe level to keep it at?

1. Discuss reasonable limits. Each person should commit him/herself to a single BAC limit.

Push those who choose a limit over 40 mg%.
ii. Discuss what constitutes "a drink" (from Miller & Munoz, 1976, p. 12).

One drink is the amount of beverage that contains a half-ounce of pure ethyl alcohol. That's the amount in one bottle of beer (12 oz.; 360ml.), or in one glass of table wine (2 1/2 oz.; 75ml.), or in one ounce of distilled spirits (30 ml.). That's right, these drinks all contain the same amount of alcohol. When you use tables 1-1 through 1-4, count one "drink" for every bottle of beer, glass of wine, or ounce of spirits you consume.

iii. if 1 drink =

one 12 oz. bottle/can of beer
one 4 oz. glass of table wine
one 2 1/2 oz. (small) glass of fortified wine
or one oz. of hard liquor

Then:

one bottle of table wine = 8 drinks
one bottle of fortified wine = 11 drinks
one fifth of liquor = 25 drinks
one pint of liquor = 13 drinks

c. Use tables 1-1 through 1-4 to decide how much they can drink per 1, 2, 3, and 4 hours. Stress that drinking should never go on for more than 4 hours because that will almost always result in over-the-limits drinking.
### Table 1-1
Approximate Blood Alcohol Concentration (mg%) Reached After One Hour of Drinking, According to Body Weight and Number of Drinks Consumed

<table>
<thead>
<tr>
<th>Number of Drinks</th>
<th>100</th>
<th>120</th>
<th>140</th>
<th>160</th>
<th>180</th>
<th>200</th>
<th>220</th>
<th>240 lb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Weight</td>
<td>45</td>
<td>54</td>
<td>63</td>
<td>72</td>
<td>81</td>
<td>90</td>
<td>99</td>
<td>108 kg.</td>
</tr>
<tr>
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<td>20</td>
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</tbody>
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### Table 1-3
Approximate Blood Alcohol Concentration (mg%) Reached After Three Hours of Drinking, According to Body Weight and Number of Drinks Consumed

<table>
<thead>
<tr>
<th>Number of Drinks</th>
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<th>120</th>
<th>140</th>
<th>160</th>
<th>180</th>
<th>200</th>
<th>220</th>
<th>240 lb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Weight</td>
<td>45</td>
<td>54</td>
<td>63</td>
<td>72</td>
<td>81</td>
<td>90</td>
<td>99</td>
<td>108 kg.</td>
</tr>
<tr>
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### Table 1-2
Approximate Blood Alcohol Concentration (mg%) Reached After Two Hours of Drinking, According to Body Weight and Number of Drinks Consumed

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<th>Number of Drinks</th>
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<th>160</th>
<th>180</th>
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<tbody>
<tr>
<td>Body Weight</td>
<td>45</td>
<td>54</td>
<td>63</td>
<td>72</td>
<td>81</td>
<td>90</td>
<td>99</td>
<td>108 kg.</td>
</tr>
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### Table 1-4
Approximate Blood Alcohol Concentration (mg%) Reached After Four Hours of Drinking, According to Body Weight and Number of Drinks Consumed

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<th>140</th>
<th>160</th>
<th>180</th>
<th>200</th>
<th>220</th>
<th>240 lb.</th>
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</thead>
<tbody>
<tr>
<td>Body Weight</td>
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<td>54</td>
<td>63</td>
<td>72</td>
<td>81</td>
<td>90</td>
<td>99</td>
<td>108 kg.</td>
</tr>
<tr>
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<td>110</td>
<td>100</td>
<td>90</td>
<td>80</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>200</td>
<td>160</td>
<td>130</td>
<td>120</td>
<td>110</td>
<td>100</td>
<td>90</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>240</td>
<td>190</td>
<td>160</td>
<td>140</td>
<td>130</td>
<td>120</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>270</td>
<td>220</td>
<td>180</td>
<td>160</td>
<td>140</td>
<td>130</td>
<td>120</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>300</td>
<td>250</td>
<td>210</td>
<td>180</td>
<td>160</td>
<td>140</td>
<td>130</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>330</td>
<td>280</td>
<td>210</td>
<td>180</td>
<td>160</td>
<td>140</td>
<td>130</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>360</td>
<td>310</td>
<td>260</td>
<td>230</td>
<td>200</td>
<td>180</td>
<td>160</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Here's how to use the tables. Notice first of all that there are four tables. Table 1-1 will tell you the BAC level you would reach by drinking a certain number of drinks within one hour. Table 1-2 will tell you what BAC level you would reach by consuming a certain number of drinks within two hours. Tables 1-3 and 1-4 provide the same information for three and four hours.

Begin with your body weight. Round your weight to the nearest 20 pounds. If you weigh less than 100 or more than 240 pounds you'll have to make do with those weights to use the tables.

Let's use table 1-1 as an example. Find your body weight along the top of the chart. Now select a BAC level. For practice let's choose 80. Run your finger down the column with your body weight until you come to this BAC level, or a level close to it. When you find it, run your finger across this row to the left in order to find the number of drinks it would take to reach this BAC level within one hour. The number of drinks is four for 80 mg% and 160 pounds. For 180 pounds and 70 mg% it is also four drinks. The tables for two, three and four hours each work the same way.

d. Have them record the number of drinks they have agreed to on the personal agreement card

i. Discuss daily (1/2 x 4 hour total) and ( 3 x
4 hour total) limits

ii. Have them sign and date card. Urge they carry it with them.

2-2

I. Self-Control Rationale

Many of your friends, and many of you, perhaps, believe that you can’t control your drinking. You may believe that because you are an alcoholic, or because you are an Indian that there is something wrong with your body which causes you to drink, or won’t allow you to stop. Unfortunately, that’s not true for everybody. And you’re the only person who knows whether it’s true for you or not. For many people it’s a myth which the white man has come up with. And the result of this is that you believe it, it makes you feel bad about your body and the way it works and you therefore have a lot of trouble becoming independent of the white man. So it really works in his favor and not yours.

Think about it. When did you first hear that there was something wrong with Indian’s bodies which makes them drink? It was probably from a white man. Or if it was from a blood, he probably heard it from a white man.

The fact of the matter is, you may well drink because you want to—because it makes you feel good, or better. There is a part of you that has always known that but it’s a hard thing for any of us to admit. You also know that many of you
can stop drinking when you want to—for funerals, ceremonies and other occasions. Think of all the times you may have stopped drinking for days, weeks, or even months—and when you’re honest with yourself you know it’s because you chose to stop drinking at those times. If you believe otherwise you are probably believing a myth the white man invented which keeps you powerless.

If it’s that easy, why don’t you just quit drinking you ask? Well, it’s not that easy and we all know that. What’s been missing is the skills you can use to control your own drinking, as an Indian, in control of your own life. Those are the skills we’re going to talk about.

Discuss the above paragraph, especially their emotional reaction to it.

Two things are essential in this discussion. First, it is important that whatever anger they might express be directed at the drinking with which the white man manipulates the Indian, not at the white men directly. The latter emotion, while appropriate may not have as much therapeutic utility. Second, clients may recall ceremonies, funerals, etc. for which they could not get sober. Direct conversation away from those occasions and toward times when they could to make the point that drinking can be under their control.

2. RELAPSE PREVENTION RATIONALE.

If you’ve chosen abstinence as your goal, you may wonder why
we should talk about drinking at all. After all, you’ve chosen to never drink again, and you intend to stick with that choice.

Abstinence is an excellent goal to choose. And we’re going to do everything we can to help you stick with that goal. Nonetheless, you and I both know, that based on your past experience, sooner or later you may very likely have a drink or two—six months from now, a year, or 3-5 years. And it’s really important to me that when you have that drink, you don’t go into a tailspin which puts you totally off the wagon. And drunk again.

So I’m going to teach you some skills which will keep you on the wagon, skills that you can practice right along to prevent you from drinking. And should you have that drink or two, you can use these skills to jump right back on the wagon and not get drunk. How does that sound?

3. Reliability Enhancement Package

We’ve been looking at the results of the questionnaires you filled out at the beginning, and it appears you have a strong need for other people to like and admire you, you pride yourself as being an independent person and are an honest individual, so...

We have reason to believe that you are honest in evaluating your own performance and have a high degree of personal integrity. Because the information you will be giving us
tends to be extremely accurate and truthful, any modifications in the treatment program we may later make are apt to be a direct reflection of the data you report. Therefore, if you inaccurately report how you are doing, it may result in a significant waste of time, money, and energy for us all. If you give us inaccurate information we could possibly change the program for other people in the future in a way which is inefficient or even harmful to them. Therefore, anything other than honest reporting could hurt other people we later treat.

4. Introduce AIS -- How to use them. (A fuller summary can be had from Miller & Munoz, 1976, pp. 29-40).

1. ALWAYS carry two or three of these with you in a pocket, wallet or purse, along with a pen or pencil.

ii. EVERY TIME you have any alcoholic beverage anywhere, write on the card what kind of drink it is and how much you are drinking. Some examples of this would be:

<table>
<thead>
<tr>
<th>Type of drink</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>beer</td>
<td>bottle</td>
</tr>
<tr>
<td>beer</td>
<td>glass</td>
</tr>
<tr>
<td>beer</td>
<td>tall can</td>
</tr>
<tr>
<td>wine</td>
<td>glass</td>
</tr>
<tr>
<td>whiskey</td>
<td>shot</td>
</tr>
<tr>
<td>screwdriver</td>
<td>l</td>
</tr>
<tr>
<td>martini</td>
<td>double</td>
</tr>
</tbody>
</table>
iii. All drinks should be recorded one at a time.

Here are some bad examples:

<table>
<thead>
<tr>
<th>Type of drink</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>beer</td>
<td>quart</td>
</tr>
<tr>
<td>beer</td>
<td>6-pack</td>
</tr>
<tr>
<td>wine</td>
<td>liter</td>
</tr>
<tr>
<td>vodka</td>
<td>pint</td>
</tr>
<tr>
<td>whiskey sours</td>
<td>5</td>
</tr>
</tbody>
</table>

iv. Remember—record one drink at a time. Drink one drink at a time. Don't let your friends "top your drink off."

v. With a little practice you will be able to write all this information down within 15 seconds or so.

vi. It is very important that you get in the habit of writing this down just before you take the first sip of the drink. If you do it this way, the record keeping helps you to be more aware of how much you are drinking. If you wait until later to write down the information, you will lose much of the benefit of this self-control method.

vii. What if somebody asks what I'm doing?

"I'm trying to cut down, and I want to keep track of my drinks."

"I'm on a diet, and I'm keeping track of everything I eat."

"I'm taking notes for the CIA."
"It's something I'm doing for a class I'm taking."

viii. Remember:
Keep a card and pen with you at all times.
Write down every drink before taking a sip.
Record the type of drink, amount, date and time of first sip.
Record one "drink" at a time.

5. Demonstrate how many ounces a drink would look like with coffee or carbonated beverage.

2-3 COLLECT MOBAT.

1. Discuss last week's AIS stressings;
   a. limits they've exceeded as agreed on in2-1
   b. difficulties and possible solutions in recording, in over the limits drinking, which are brought up now, or may have been mentioned in earlier or on the Marlatt.

2. Collect AIS forms and give them another.

3-1

1. Collect MOBAT. Collect AIS forms, give them more.

2. Discuss AIS forms for:
   a. Limits exceeded and controlled drinking days.
   b. Problems and successes they've had in recording.
   c. Events surrounding over-the-limits days and ways of coping with those events.

NOTE: The format for segment 1 will remain unchanged
throughout the rest of the treatment. It's purpose is to focus attention on the drinking recorded by the AIS and to keep clients recording accurately as well as to instill in them a habitual and regular awareness of how much they are drinking. It is therefore important to:

1. Make sure they offer some indication as to how they are doing.

ii. Verbally praise all good days of within limits drinking.

iii. Verbally praise all good recording, whether it is of within limits days or not.

iv. Deal with over-the-limits days in a straightforward fashion. The cues which set the drinking off were not adequately anticipated and changed, the options to drinking were not utilized, how can these things be avoided in the future? The drinking itself should not be the focus.

3-2 Collect MOBAT

1. Stimulus control training.

Your ancestors survived by hunting, fishing and gathering wild foods. For each of these tasks they needed sharp senses, the ability to look around them and see the signs which led them to food. They were quiet, sensitive observers who knew what was going on around them at all times, in order to survive.

To survive in today's world, we Indians still need to be
sensitive to what's happening around us, to recognize the signals of things which are to come. The important set of cues we're interested in now is those which usually begin us drinking over the limits we've set.

2. Discuss and elicit with clients ways in which the following cues precede over-the-limits drinking for them. Also use what they've mentioned in earlier discussions of the AIS, as well as data from their Marlatt Drinking Profiles.

   a. Time of day—noon, night
   b. Time of week—weekends, Mondays
   c. Time of month—checks come, bill come, holidays
   d. Other drinking friends
   e. Physical exhaustion
   f. Feeling "down", blue
   h. Particular bars, people's homes
   i. Having extra money or extra liquor with you
   j. Particular booths, stools, chairs where you drink
   k. Particular drinks, e.g. a whiskey and beer chaser
   l. Others mentioned by them or from their Marlatt Drinking Profile.

3. Discuss ways in which these can be naturally avoided, i.e., ways in which these situations can be easily and conveniently avoided or made less "dangerous" for abusive drinking.
4. Rate training.

In addition to being hunters and stalkers, our ancestors were very resourceful. They could substitute, change plans and learn to do things differently depending on the weather and availability of food. Maize, potatoes, sweet potatoes and manioc, which today make up more than 1/2 of the world’s tonnage of staple foods, were first domesticated by American Indians. Most modern cotton, including that grown in Europe and Asia, is the long-staple cotton of the American Indian. Some 220 of the American herbs and medicines have been or still are officially used.

We must utilize this creativity and resourcefulness in controlling our drinking. We should not be forced or trapped to drink in any one way. We have options. We can choose.

a. What to drink:

Don’t drink:

malt liquor
cocktails—martinis, manhattans
liquor straight or on the rocks
doubles
port, muscatel, vermouth

If you choose to drink, then:

“and’s”—scotch and soda, gin and tonic
beer
table wine
b. The following rates should keep most people within their limit:

- 60 secs/sip
- 30 sips/drink
- 15 mins between drinks

--use a glass of water or cup of coffee to demonstrate.

3-3 COLLECT MOBAT.

1. Discussion of interactions between culture and alcohol
   a. Simply raise these issues one at a time and facilitate discussion
   b. Focus upon, reflect back and do whatever else you can to underscore how they feel about these issues and not what they think about them.

i. For every dollar you spend on liquor:
   - 17 cents goes to manufacturer (who's white)
   - 33 cents goes to wholesaler/distributor (who's white)
   - 42 cents goes to owner of bar or store (who may be white)
   - He keeps 30 cents, 12 cents goes to bartender or employee who may be Indian
   - 4 cents goes to state government—white controlled

ii. It was unofficial policy for white traders for the Hudson's Bay company or white officials renegotiating a treaty to serve large amounts of brandy or whisky before making a deal with a tribe, so they'd be drunk and more
willing to agree on the white man's terms.

iii. Red Jacket, a Seneca Chief in the 1800's, told white settlers, "We gave you corn and meat. You gave us poisonous liquor in return."

4-1

1. Collect AIS forms, give them more

2. Discuss AIS forms (g.f.3-1)

4-2 COLLECT MOBAT

1. Discuss AIS forms utilizing:

a. Information they have about antecedent cues—elicit them, discuss ways in which they led to over-the-limits drinking, ways in which they could have been avoided or substituted for.

b. Rate-training—did they drink at rates prescribed? Did they watch their rate? What problems did they encounter?

4-3 COLLECT MOBAT.

Social skills training

1. Rationale—People with drinking problems usually have two other difficulties when they interact with other people.

a. They have a hard time saying while they're sober what they don't like, what they don't want and what they're dissatisfied with (negative assertion.)

b. They have a hard time saying "no" to others who want them to drink.

2. Read each item, one at a time, eliciting response to
each item from clients. Be sure to elicit actual responses as if the person were actually in the situation, and not just discussion about the situation.

a. Money has been tight for some time. Your husband or wife has been grouchy all morning. He or she has been picking on you about all sorts of little things. Finally, he or she goes on and on about how you're nothing but a lazy Indian. When they're finally done you say...”

b. You bought a new television a few months ago. You had the money for the down payment, and made a few more payments, but ever since then you've been really broke. Now, a white bill collector from the store at which you bought the t.v. calls you up and gives you a really hard time. He calls you names like stupid s.o.b of an injun and threatens to take the t.v. back. finally you say...

c. Your kids have been "mouthy" all day. Every time you say or do something they've got a smart answer. Finally, after your oldest child laughs in your face and calls you "a drunk old Tom-Tom", you've had enough of it, and you say...

d. You're applying for a job. You've waited and waited, filled out their forms, not knowing how to answer some questions and being unsure of your spelling of others. Finally you're done and you hand the forms to the white lady who gave them to you. She says, We'll keep you on file and call you if anything comes up." You say...
e. Finally you get a chance to talk to the white guy who can hire you. He goes on and on about how hard it is to get decent laborers these days because all the Indians are lazy and drunk. You figure he's putting you down, so you say...

f. In the same situation he asks you if you have a drinking problem, so you say...

g. It's the end of a very long, hassling day. Nothing seemed to go right and you're feeling very "down". On your way home you pass a familiar bar. The lights inside look warm and inviting. You know several of your friends will be inside, and they'll doubtless buy you a round or two, and you'll feel much better for it. As you approach the door you run into another friend on his way in. He greets you and says, "C'mon in, I'll buy you one. You look as if you could use it." You suddenly realize this could be the beginning of a long night of drinking. So you say...

h. At a different bar, you've had one with old friends from the reservation and you've been at the bar for over an hour. You get ready to leave, and a friend catches you by the arm and says, "You can't go yet, I've got to buy you one." You want to go home and be with your family, so you say...

i. In the same situation your friend says, "C'mon, you gotta stay and have a couple. What are you, too good to
drink with us? Don't worry about nothing, we're your friends, we'll take care of you." You say...

3. Review of the responses
   a. Now go back over the items, starting with the one response you judged to be most inadequate.
   b. Ask the client to repeat their original response.
   c. Explain the criterion by which you judged the response to be inadequate and describe how a more adequate response would be more effective.
   d. Model what you consider to be an adequate response along the criterion you've just described.
   e. Ask the client to put a similar response in his own words.
   f. If necessary, model again, and ask for another attempt from the client.
   g. Once the client's response meets your criterion, reread the item and have them repeat the response at the end.
   h. VERBALLY REINFORCE as you go.
   i. Move on to the next weakest response, as you judge it, trying to introduce a new criterion, if possible. You should go over at least 3-4 responses before you quit, hopefully all eight.

a. **Length.** Long response of a few sentences are more convincing than short response of a few words.

b. **Loudness** People listen to loud responses, said in a firm tone of voice.

c. **Noncompliance.** The responder does not give in to something he does not want to.

d. **Affect** Emotional commitment to what one is saying by facial expression, tone of voice, gestures. The person is not smiling in a phony way, the person's posture is relaxed and tone is strong.

e. **Eye-contact** Eyes are directed at the other person, if not directly in his eyes.

5. **Criterion for content of response**

a. Request a change in the other person's behavior now and in the future, that is. "Please don't pressure me to do something that I don't want to do and don't try to do it again, later, either."

b. Offer an alternative, for example, "Look, why don't you come over to my place for a cup of coffee and see my wife and kids. They'd love to see you."

c. Change the subject.

6. **Collect AIS forms and give them another 5-1:**

   1. Collect MOBAT. Collect AIS forms, give them more.
   2. Discuss AIS forms (g-f.3-1)
5-2 COLLECT MOBAT

1. Discuss AIS forms, utilizing:
   a. Negative assertiveness skills
   b. Drink refusal training
   c. Antecedent and rate training

5-3 COLLECT MOBAT. Progressive relaxation.

1. Rationale
   a. Because we all need to learn to relax
   b. Because when we get up tight, we can do this rather than drink
   c. Because this will help other things we are going to learn later
   d. Our minds must be set on the task of controlling our drinking. As our ancestors went off to a mountain in search of a vision, so we must go inside ourselves, and there, emptied of everything else, seek our own solutions. Black Elk says those in search of a vision, "... must be careful lest distracting thoughts come to him." We are going to work on controlling those distracting thoughts.

2. Allow them to relax naturally, shoes and glasses off, wallets, etc. out of pockets, laying on the floor with rolled up jackets under their heads if they prefer.
   a. Procedure for each muscle group—tighten five seconds, relax 15 secs., repeat, go on to next muscle group
   b. muscle groups—see below from Miller & Munoz, 1976,
1. Hands. Tighten your hands by making a fist and squeezing.

ii. Forearms and back of hands. With your arms resting on the chair and the back of your hands facing up, bend your hand at the wrist, pointing your fingers straight up.

iii. Biceps. Flex the muscles in your upper arm as if you were "making a muscle".

iv. Shoulders. Bring your shoulders up as if to touch your ears with them.

v. Forehead. Wrinkle your forehead by bringing your eyebrows up as far as they will go.

vi. Face. Wrinkle your nose up and close your eyes as tightly as you can.


viii. Tongue. Push your tongue into the roof of your mouth.

ix. Neck. Press your head against the back of the chair.

x. Chest. Take a breath that is so deep that you can feel it stretch your chest muscles. Hold it.

xi. Stomach. Suck in and tighten your abdomen, as though preparing to take a punch in the stomach.

xii. Back. Arch your back away from the chair.
xiii. Legs and thighs. Lift your legs up from the chair, holding them straight out in the air.

xiv. Calves. Point your toes back toward your chest, creating tension in your lower legs.

xv. Feet. Curl your toes downward, as if digging them into the sand.

c. Order of muscle groups—
   i. hands, forearms, and back of hands
   ii. biceps
   iii. shoulders
   iv. everything above together
   v. forehead, face, lips and tongue
   vi. everything above together
   vii. neck
   viii. chest
   ix. stomach
   x. back
   xi. vii. - x. together
   xii. everything together
   xiii. legs, thighs, calves and feet
   xiv. everything together

d. Phrases with which to call attention to experienced relaxation during 15 sec.:

"Concentrate on the relaxation... allow the muscles to go limp... let them go loose... feel that lack of tension... let
them relax...pay attention to the muscles relaxing...feel the tension fade away...keep letting it relax more and more...just let it go...just let the muscles go limp...just let go...Concentrate on the feeling...feel how good it feels...nice and loose with no tension whatsoever."

  e. Concentrate on slower, deeper breathing

  f. Have them sit up straight and open their eyes at their own rate

  3. Discuss relaxation as an option to drinking, as a reaction to stress rather than drinking

  4. Collect AIS forms and give them another.

  6-1  1. Collect MOBAT. Collect AIS forms, give them more.

  2. Discuss AIS forms (see 3-1)

  6-2 COLLECT MOBAT

  1. Discuss AIS forms utilizing:

     a. relaxation as an alternative to drinking

     b. negative assertiveness and drink refusal training

     c. antecedent and rate training

  2. Collect AIS and hand out new one.

  3. Move quickly (no more than 15 mins.) through relaxation procedure. (5-3)

  6-3 COLLECT MOBAT.

  1. Covert rehearsal. Read through each of the nine items. Begin with Imagine...", elaborating as you go using cues
from 3-2 which have been discussed in treatment as being particularly salient. Create a clear mental image, providing endings below. Repeat the provided ending several times, saying the words to allow them to visualize the response of the other person.

a. Money has been tight for some time. Your husband or wife has been grouchy all morning. He or she has been picking on you about all sorts of little things. Finally, he or she goes on and on about how you’re nothing but a lazy Indian. When they’re finally done you say... “Look, I know things haven’t been going too well lately, and I’m sorry that they aren’t. But there are a lot of things which are out of my control. So stop criticizing me when I’m doing the best that I can. If I’m such a lazy Indian, maybe you should work with me instead of against me all the time. Your wife or husband seems satisfied with that and although he or she looks like they’d like to say something else, instead he or she pours a cup of coffee.

b. You bought a new television a few months ago. You had the money for the down payment, and made a few more payments, but ever since then you’ve been really broke. Now, a white bill collector from the store at which you bought the t.v. calls you up and gives you a really hard time. He calls you names like stupid s.o.b of an injun and threatens to take the t.v. back. Finally you say... “I haven’t had the
money to make the last few payments. I expect some money soon, and I’ll pay you what I can then. If that isn’t good enough, then you’ll have to come and get the t.v. Regardless of what you decide, I resent your anger and hostility and insults against my race. I’m surprised a reputable place like the one from where I bought the t.v. would hire a foul-mouthed person like you.” The fellow on the other end of the phone is quiet, and then he mumbles something and hangs up.

c. Your kids have been “mouthy” all day. Every time you say or do something they’ve got a smart answer. Finally, after your oldest child laughs in your face and calls you “a drunk old Tom-Tom”, you’ve had enough of it, and you say... “You kids have been mouthy all day. I don’t like it. I resent your lack of respect and courtesy. It only makes life rougher for me. If there’s something specific you don’t like, let’s talk about it.” Your oldest child looks at you with what appears to be some little respect, and then asks you for five dollars. The two of you talk about it.

d. You’re applying for a job. You’ve waited and waited, filled out their forms, not knowing how to answer some questions and being unsure of your spelling of others. Finally you’re done and you hand the forms to the white lady who gave them to you. She says, We’ll keep you on file and call you if anything comes up.” You say... “I need the work
very badly. I’ll be fine worker and a good employee. Please be sure to call me as soon as some job comes open.” The woman looks you straight in the eye and says, “Well, O.K., thanks.”

e. Finally you get a chance to talk to the white guy who can hire you. He goes on and on about how hard it is to get decent laborers these days because all the Indians are lazy and drunk.
You figure he’s putting you down, so you say... “I can see where keeping good people is difficult. That’s why it’s important for you to hire me. In addition to being an Indian, I’m me, an individual. I’ll work hard for you and be a good employee.” He looks you in the eye and says, “Well, what kind of work would you like?” The two of you begin to talk about a job.

f. In the same situation he asks you if you have a drinking problem, so you say... “Yes, I used to drink too much. But I’m working very hard on controlling it with the help of some other people, and I’ve been quite successful for a while now.” He looks puzzled, and then says, “Well, alright, I hope you stick with it.”

g. It’s the end of a very long, hassling day. Nothing seemed to go right and you’re feeling very “down”. In your way home you pass a familiar bar. The lights inside look warm and inviting. You know several of your friends will be
inside, and they'll doubtless buy you a round or two, and
you'll feel much better for it. As you approach the door you
run into another friend on his way in. He greets you and
says, "C'mon in, I'll buy you one. You look as if you could
use it." You suddenly realize this could be the beginning of
a long night of drinking. So you say... "I'd really like to
spend some time with you, and I am feeling really down. But
I'm trying to control my drinking and I don't want to be
talked into drinking too much by you or the other folks. Why
don't you come on home with me and have dinner with the
family and me?" He turns you down, but you shake hands and
you go your separate ways.

h. At a different bar, you've had one with old friends
from the reservation and you've been at the bar for over an
hour. You get ready to leave, and a friend catches you by
the arm and says, "You can't go yet, I've got to buy you
one." You want to go home and be with your family, so you
say..."Thanks alot, but I want to go home and be with my
family. But I'd really like to spend some time with you,
too. Why don't you come on home with me and let me make you
a cup of coffee?" He says, "Aw, c'mon. The family'll wait.
C'mon and have a few with your friends."

i. In the same situation your friend says, "C'mon, you
gotta stay and have a couple. What are you, too good to
drink with us? Don't worry about nothing, we're your
friends, we'll take care of you." You say, "I know you're my very good friends, and that's very important to me. You're also a blood and that's very important. That's why I invited you to my home. Because you're my friend, you also know that I often drink too much. And I want you as my friend and as a fellow Indian to help me with that problem and not pressure me to drink more." I'm not too good to drink with you. But I refuse to be controlled by the white man's liquor. You're too good for that. All of us are. So come to my home and share our friendship. He says, "Oh, all right, I'll stop by your place later."

7-1

1. Collect MOBAT. Collect AIS forms, give them more.
2. Discuss AIS forms (See 3-1)

7-2 COLLECT MOBAT

1. Discuss AIS forms, utilizing:
   a. Responses provided in covert rehearsal
   b. Relaxation as an alternative to drinking
   c. Negative assertiveness and drink-refusal training
   d. Antecedent and rate training.
2. Collect AIS and hand out new one.
3. Go quickly through relaxation procedure (5-3).

7-3 COLLECT MOBAT. Covert reinforcement

1. Now we're going to imagine a few things so you can get a few pictures in your mind very clearly. We'll be using
these pictures later, so get them very clearly in your mind now.

a. We'll call this first picture the picture of you. You've just gotten up in the morning. You're still a bit sleepy. You go over to the mirror and look in. For the first time in a long time you notice some very attractive features in your face. You lean over to look closer and you realize that your complexion is clearer. Your eyes are clearer and your head is clearer. A sense of clearness moves through your whole body. You take a deep breath wondering if you're still dreaming. Your lungs feel clearer. From your toes to the top of your head, throughout your stomach and shoulders out into both your hands you feel clear and clean and strong. You feel confident and strong, and you realize how good you can feel without alcohol. We'll call this first picture the picture of you.

b. We'll call this second picture, your favorite place.
Imagine a place, you've been there several times before, it may be indoors or outdoors, but it's probably outdoors, and imagine yourself in the middle of this place. There are very noticeable colors which you see clearly, there are scents and odors there which are good and very strong, there are sounds--quiet pleasant sounds which make you happy. You reach out to touch something there and your hands feel the
texture of the thing you touch and you are amazed at how good and natural it feels. And when you breath in you can almost taste the good clean air. You've never sensed this place like this before, and you wonder if it's all a fantasy, but it's all very, very good. And you are in the middle of it. Sober and peaceful. We'll call this second picture, your favorite place.

c. We'll call this third picture, your family picture. You are surrounded by your family. Relatives young and old are seated or standing, talking. The younger ones are playing and some run by. There seems to be no anger or harsh words, just warm friendliness and a general peacefulness. One by one you speak with each of them, and each in their own way tell you how pleased they are that you are controlling your drinking. The older ones say so in brief, wise phrases. The younger ones say nothing, but you can tell by the way they act around you they have a new respect for you. The ones your age kid you a bit, but you can see through the kidding that they envy your strength of mind and strong will. "So," you think, "here I am. Father, son, husband, mother, daughter, wife, niece, nephew, uncle, aunt; surrounded by those I love and who love me. This is as it should be. I am a good person and do not need to drink. These people need me."

2. Go through all 9 items as in week 6, with the new
materials provided below. Remember, again, to elaborate as you go, using cues which have been mentioned in previous sessions as particularly important in eliciting over-the-limits drinking for this client.

a. Money has been tight for some time. Your husband or wife has been grouchy all morning. He or she has been picking on you about all sorts of little things. Finally, he or she goes on and on about how you’re nothing but a lazy Indian. When they’re finally done you say..."Look, I know things haven’t been going too well lately, and I’m sorry that they aren’t. But there are a lot of things which are out of my control. So stop criticizing me when I’m doing the best that I can. If I’m such a lazy Indian, maybe you should work with me instead of against me all the time. Your wife or husband seems satisfied with that and although he or she looks like they’d like to say something else, instead he or she pours a cup of coffee. You breathe a sigh of relief and feel your body relaxing. You think that you should have told them what was on your mind a long time ago, and feel that now perhaps she understands your concern, too. Now bring back into your mind, your family picture.

b. You bought a new television a few months ago. You had the money for the down payment, and made a few more payments, but ever since then you’ve been really broke. Now, a white bill collector from the store at which you bought
the t.v. calls you up and gives you a really hard time. He calls you names like stupid s.o.b of an injun and threatens to take the t.v. back. Finally you say..."I haven't had the money to make the last few payments. I expect some money soon, and I'll pay you what I can then. If that isn't good enough, then you'll have to come and get the t.v. Regardless of what you decide, I resent your anger and hostility and insults against my race. I'm surprised a reputable place like the one from where I bought the t.v. would hire a foul-mouthed person like you." The fellow on the other end of the phone is quiet, and then he mumbles something and hangs up. You hang up the phone and feel good that you told the guy what you thought. He didn't have a right to talk to you that way, and you didn't let him. Now bring into your mind the picture of you.

c. Your kids have been "mouthy" all day. Every time you say or do something they've got a smart answer. Finally, after your oldest child laughs in your face and calls you "a drunk old Tom-Tom", you've had enough of it, and you say..."You kids have been mouthy all day. I don't like it. I resent your lack of respect and courtesy. It only makes life rougher for me. If there's something specific you don't like, let's talk about it." Your oldest child looks at you with what appears to be some little respect, and then asks you for five dollars. The two of you talk about it. As you
talk with him it occurs to you that you really do care about this kid, and you're glad you took the time to talk to him. Now bring into your mind your family picture.

d. You're applying for a job. You've waited and waited, filled out their forms, not knowing how to answer some questions and being unsure of your spelling of others. Finally you're done and you hand the forms to the white lady who gave them to you. Now bring into your mind the picture of your favorite place. She says, "We'll keep you on file and call you if anything comes up." You say... "I need the work very badly. I'll be fine worker and a good employee. Please be sure to call me as soon as some job comes open." The woman looks you straight in the eye and says, "Well, O.K., thanks." As you walk out of the office, you feel strong and warm inside. You told the woman you needed the work and she seemed to respond favorably to you. Now bring into your mind the picture of your favorite place.

e. Finally you get a chance to talk to the white guy who can hire you. He goes on and on about how hard it is to get decent laborers these days because all the Indians are lazy and drunk. You figure he's putting you down, so you say..."I can see where keeping good people is difficult. That's why it's important for you to hire me. In addition to being an Indian, I'm me, an individual. I'll work hard for you and be
a good employee." He looks you in the eye and says, "Well, what kind of work would you like?" The two of you begin to talk about a job. As you talk, he seems to be warming up to you. It occurs to you that you can be an honest, straightforward person and people like that in you. Now bring into your mind the picture of you.

f. In the same situation he asks you if you have a drinking problem, so you say..."Yes, I used to drink too much. But I'm working very hard on controlling it with the help of some other people, and I've been quite successful for a while now." He looks puzzled, and then says, "Well, alright, I hope you stick with it." You sort of relax inside. You've told him straight out how you're trying, and if he wants to hold that against you, well that's his problem. Now bring into your mind the picture of your favorite place.

g. It's the end of a very long, hassling day. Nothing seemed to go right and you're feeling very "down". In your way home you pass a familiar bar. The lights inside look warm and inviting. You know several of your friends will be inside, and they'll doubtless buy you a round or two, and you'll feel much better for it. As you approach the door you run into another friend on his way in. He greets you and says, "C'mon in, I'll buy you one. You look as if you could use it." You suddenly realize this could be the beginning of
a long night of drinking. So you say... "I'd really like to spend some time with you, and I am feeling really down. But I'm trying to control my drinking and I don't want to be talked into drinking too much by you or the other folks. Why don't you come on home with me and have dinner with the family and me?" He turns you down, but you shake hands and you go your separate ways. As you walk towards home, you are reminded that you are frequently a warm, considerate person who works hard at keeping friends. You feel good about that.

Now bring into your mind the picture of you.

h. At a different bar, you've had one with old friends from the reservation and you've been at the bar for over an hour. You get ready to leave, and a friend catches you by the arm and says, "You can't go yet, I've got to buy you one." You want to go home and be with your family, so you say... "Thanks a lot, but I want to go home and be with my family. But I'd really like to spend some time with you, too. Why don't you come on home with me and let me make you a cup of coffee?" He says, "Aw, c'mon. The family'll wait. C'mon and have a few with your friends." You begin to feel a little irritated. Your "friend" is trying to talk you into something you really don't want to do. But you like him, so you decide to explain again. Now bring into your mind your family picture.

i. In the same situation your friend says, "C'mon, you
gotta stay and have a couple. What are you, too good to
drink with us? Don't worry about nothing, we're your
friends, we'll take care of you." You say."I know you're my
very good friends, and that's very important to me. You're
also a blood and that's very important. That's why I invited
you to my home. Because you're my friend, you also know that
I often drink too much. And I want you as my friend and as a
fellow Indian to help me with that problem and not pressure
me to drink more." I'm not too good to drink with you. But I
refuse to be controlled by the white man's liquor. You're
too good for that. All of us are. So come to my home and
share our friendship. He says, "Oh, all right, I'll stop by
your place later." Now you feel as if he sort of
understands. As you begin to leave you are reminded that you
are a friendly person and lots of people like you for it.
But you are not going to let your friends tell you how to
drink, and there are lots of people who respect you for
that. Now bring into your mind the image of your favorite
place.

8-1 Post-treatment assessment

1. Collect MOBAT. Collect AIS forms
2. Discuss AIS forms (see 3-1). Collect them.
3. Administer MAST.

8-2 COLLECT MOBAT

1. Administer Marlatt Drinking Profile.
8-3 COLLECT MOBAT.

1. Explain follow-up procedures
   a. give them treatment summary card
   b. say good bye.
   c. Follow-up schedule

2. 11 question follow-up: weeks 2, 4, 8, 16, 20

3. Three month follow-up (Marlatt and MAST) week 12

4. Six month follow-up Week 24
Problems of Implementation

A number of comments upon the above treatment program may assist the therapist in using the program more immediately.

The MOBAT is an inexpensive (about $0.50 per administration) instrument for the measurement of blood alcohol concentration (BAC) (Sobell and Sobell, 1975). The client can be scheduled to take the breath sample to the treatment offices or in the field twice weekly at times when the Marlatt interviews indicate the client is likely to be intoxicated but is not being seen in a regular therapeutic session. The resulting color-coded tabs can be interpreted to the client immediately and the results recorded. The instrument is calibrated to three levels of blood alcohol concentration: (*00-.08, sober; .09-.16 intoxicated; .17-.25, very intoxicated) and can readily be used to distinguish intoxicated from non-intoxicated subjects for the purposes of this program. Used in this fashion throughout treatment it can provide a rough measure of intoxication frequency, simply by dividing the number of days on which intoxication is measured (.09 BAC or above) by the total number of MOBAT measurements.
Although at first it is somewhat awkward to administer
the MOBAT because it implies a certain mistrust of
self-report, it has been our experience that when the
rationale for the MOBAT measurement is used as above, the
overt resistance by clients is negligible. The MOBAT is
available from Luckey Laboratories (7252 Osbun Rd., San
Bernadino, CA., 92404).

The therapeutic contract and personal choice of
drinking limits (Session 2-1) are two relatively essential
components of treatment. At these times the client overtly
and specifically commit themselves to treatment, thereby
making the treatment goals their own and not merely the
therapist's.

Clients may also be asked to sign a therapeutic
contract indicating their intent to remain in treatment
throughout the program. They can also be asked to choose a
level of drinking or abstinence which they will attempt to
maintain throughout treatment (Appendix K.). Gottheil and
his associates (Thornton, Gottheil, Gellens & Alterman,
1977) have found that voluntary choice of abstinence or a
non-abusive level of drinking early in therapy facilitates
favorable outcome.
The reliability enhancement package (Pretreatment & Session 2-1) is also important, for it has been demonstrated (Bornstein, Hamilton, Miller, Quevillon & Spitzform, 1976) that this package significantly increases the accuracy of the client's self-report on self-monitoring tasks.

The relapse prevention rationale (Session 2-2) is essential for all clients choosing abstinence as a treatment goal. If the client has chosen abstinence, many of the treatment tasks will seem superfluous to him unless s/he can conceive of them as preparatory training for the day when s/he may have a drink or two.

Mention was made in the fourth chapter of utilizing visual Indian symbolism to assist treatment. As one limited attempt at this in our pilot study all forms, including the daily Alcohol Intake Record, were printed with the treatment agency's logo (cf. Appendix A)—the profile of an Indian warrior.

Several follow-up contacts using either the Marlatt Drinking Profile or the Social Adjustment Indices as measurements are suggested after the completion of formal treatment. Whether they are conducted by mail, phone or in person, they serve two purposes. First they establish the extent to which treatment was successful. Although few persons classified as treatment failures at three months are
later reclassified as successes (Sobell & Sobell, 1974), there is a continued decrease in the number of treatment successes up to twelve months (Gerard & Saenger, 1959; Sobell & Sobell, 1978). After twelve months the proportion of successes to failures stabilizes. Second, Gallen (1974) points out that follow-ups not only facilitate the collection of data but very likely serve a therapeutic purpose.

Three paper-and-pencil measurement instruments are recommended in the program: the Marlatt Drinking Profile (MDP), the Alcohol Intake Sheet (AIS) and the Social Adjustment Indices (SAI). It should be noted that the first two serve primarily therapeutic purposes and only secondarily data-gathering purposes. For this reason it is not expedient to eliminate them from the program. Data gathered from the MDP should be used in the stimulus control training and the covert techniques. The AIS is instrumental in fostering awareness of the rate and amount of alcohol consumption throughout self-monitoring training. The third instrument, the SAI, is very brief and used during the follow-up sessions.

The Marlatt Drinking Profile (Appendix D.), developed by G. Alan Marlatt at the University of Washington, is a structured behavioral interview of approximately 100
rank-ordered and open-ended questions from which the interviewer can establish details regarding the style, context and affective correlates of drinking for the interviewee. The questions include the elicitation of demographic data in sufficient detail to facilitate follow-up. Questions also tap antecedents to drinking, beverage preference and drinking rates. Equivalent forms are available. The first form can be used at pre-treatment measurement, the second (Appendix E.) at post-treatment and follow-up. The interview requires between 45 and 60 minutes for administration.

The Alcohol Intake Sheet (Appendix B) is a simple device for the recording of daily alcohol intake by clients. It is printed on a 3 by 5" card which is easily carried on the client's person. On it s/he can record, on a daily basis, and for each individual drink, the time, environmental, social and emotional antecedents to that drink (Sobell & Sobell, 1976). It can be used throughout the eight weeks of treatment and provide a measure of daily drinking frequency.

Eleven questions can be compiled into a questionnaire to facilitate the computation of the Social Adjustment Indices (Sobell & Sobell, 1968), and can be used for follow-ups at weeks 2, 4, 8, 16 and 20 after treatment. The
Social Adjustment Indices (Appendices F. and G.) which can be derived from the eleven questions, estimate the client's occupational, marital, social and economic well-being in a straight-forward fashion (Sobell & Sobell, 1978).

Individual client progress can then be recorded on tables and charts as shown in Appendices H., I. and J.

Soliciting and maintaining clients for this treatment is a second issue which must be faced by a treatment such as this. The program was piloted at Missoula Indian Alcohol and Drug Services (MIADS) during the Spring of 1979.

MIADS is a non-profit organization funded primarily with state and federal monies. A staff of four paraprofessionals deliver various treatment services to the American Indian population of the Missoula, Montana area. Two female American Indian paraprofessionals were responsible for the primary administration of treatment.

Of the eight clients who originally committed themselves to the treatment during an extensive two month screening and recruitment period, none finished the treatment. All were American Indian males between 22 and 30 years of age who were living in Missoula. Each had experienced difficulty with alcohol abuse over a period of years, including arrests for alcohol-related incidents. Two
had chosen a controlled-drinking goal, three had chosen abstinence, three never reached the point in treatment when they chose between the goals.

Of the eight, two were hospitalized for alcohol-related physical disorders just prior to the beginning of treatment, one never appeared for pre-treatment assessment, four were arrested or left the area to avoid parole violation proceedings for alcohol-related incidents during treatment and one decided to terminate this treatment and begin disulfiram treatment only.

Apparently we had grievously failed to anticipate some of the difficulties involved in doing alcohol abuse treatment with an American Indian population.

Following an intensive and carefully-orchestrated presentation of this program, staff and clients were enthusiastic about the new program and appeared motivated to take part. It seems unlikely that lack of acceptance for the program contributed to its demise. Extensive post hoc discussion with the therapists about the failure indicated a number of difficulties which can be avoided in future implementations of a similar program.
First, it was noted that never in the history of MIADS had an attempt been made to begin a substantial number of persons in treatment at the same time. Therefore it was difficult to anticipate precisely what difficulties would be encountered in such an endeavor. Had the pilot used a clinical replication design (Hersen & Barlow, 1976, pp. 335-337), in which clients enter the program at the time they normally refer themselves to the treatment center, many of the recruitment difficulties and the debilitating effect of client drop-out could have been ameliorated. Clients can be treated (and data gathered) one or two at a time, at their normal referral rate, and substantiating data can be gathered over a longer period of time. This design seems necessary for any future attempt at a program such as this in an outpatient setting. In an inpatient setting or in a large urban area where there is a sizeable, relatively non-transient American Indian population, the treatment of several clients at one time may still be feasible.

Second, the issue of scheduling and progress through treatment appeared to be a problem. The program was originally designed to be completed in eight weeks, three sessions per week. This proved impractical for a number of reasons. The three-sessions-per-week format easily translated itself into a regular appointment at, say, 3:00 p. m.-, Monday, Wednesday, and Friday. That didn't work.
The scrupulous keeping of appointments and dividing of the day into so many working hours is often alien to the American Indian's way of doing things. Perhaps it is a vestige of the more timeless precontact Indian existence, or perhaps a reflection of the unstructured, loosely scheduled life on the reservation. Whatever its origins, the American Indian, by and large, resists a "set" appointment as artificial, unimportant and an indication that the therapeutic relationship is also. It appears to many Indians (and indeed it may well be) a convention of the white men which is unnecessary and demeaning of the relationship. Therapists were successful during the pilot study when they simply instructed the clients to appear at the center at least three times a week, on three different days, at their convenience, with the understanding that they may have to wait awhile to see the therapist. Compliance with this request was 100% as long as clients remained in treatment.

Thirdly, even during the three sessions per week, treatment did not always progress neatly as outlined above. Sometimes more than one segment's material could be covered in a session, especially at first. Other times material would have to be reviewed and repeated. Although this makes the sequence different and therefore incomparable across all clients, treatment was in this way tailored to the
individual, rather than slavishly adapted to a preset schedule.

The fourth problem involved the drinking group discussed in the first chapter. It was recognized during the first week of treatment that three of the clients frequently drank together with a fourth client, the individual who had not appeared for pre-treatment assessment. It was therefore possible for him, when drinking with the others, to derogate their efforts and belittle the treatment program, often successfully undermining the other three clients' motivation to drink within the limits they had set for themselves. It is suggested on the basis of this experience, that if this program is attempted again with several members of a peer drinking group, a concerted attempt be made to include all members of the group in treatment, if only to "help their buddies." Failing that, the therapist and client will need to look carefully at the influence of the group member not in treatment upon the client's drinking behavior during stimulus control training and come to a decision regarding how detrimental to the client's goals the other individual is.
A fifth modification suggested has to do with some reorganization in the program's content. The material which is included as part of the specific adaptation for American Indian clients does not begin until session 3-2. In most instances that will occur during the third week of treatment. It may be that this lack of culture-specific treatment content early in the program failed to maintain clients' interest in continuing the program. Perhaps if the content of the sessions Pretreatment through 3-1 were collapsed into the first three sessions, the resulting earlier introduction of culture-specific treatment content would make the treatment more attractive to clients, thus holding them in treatment longer.

Finally, five of our eight clients in the pilot study were on probation from the court or had legal charges pending. However, the outcome of their legal difficulties was in no way attached to their successful completion of treatment. Thus they were not motivated by court directive to stay in treatment and in fact, when they suspected that their probation violations had been detected or their trial dates were set, they were inclined to leave town. It is therefore recommended that future attempts either solicit clients without probation, parole or pending suits; or clients who are directed by the court to remain in treatment in return for more generous judicial settlement at the
conclusion of treatment.

These six changes, it was suggested from our pilot efforts, would constitute a more potent treatment package. Some general comments are necessary upon the problems of implementing behavioral programs in the natural environment.

First, the implementation of effective behavioral treatment and matching the demands of a real situation are often marginally incompatible tasks. Some specific aspects of treatment must be compromised for the more general welfare of the whole program. The careful reader will find in this program such compromises, especially in the rate control training segment. Others will have to make their own adjustments with programs similar to this, always weighing the realistic advantages against the loss of therapeutic impact.

Repucci & Saunders (1974) observe,

Although there is little question that behavior modification techniques have potent, predictable effects under carefully controlled conditions, psychologists have only a slight comprehension of their effects under less-than-optimal conditions usually encountered in natural settings (pp. 549-650).

One reality constraint involves simply getting to know the people involved in the organization, how they operate and cooperate, and making realistic appraisals about how the
new program can serve their interests. For the pilot of this program, seven months were required to do the necessary footwork and speak with all of the essential people, convincing them of the worth of such an effort.

There are certain constraints that occur by virtue of common institutional procedures and arise with great frequency, regardless of the particular individuals who occupy specific positions...these constraints can usually be overcome only by a considerable expenditure of time and energy by the behavior modifier or a high-ranking administrator (p. 651).

Often certain words or concepts are unpalatable for workers in the natural environment. "Controlled drinking" was such a shibboleth at MIADS. For this reason "over-the-limits" drinking was adopted as a syntactically unhappy, but pragmatically acceptable phrase, and is used frequently in the program.

For some the concept, and consequently the language, of behavior modification may provoke a clash of values; for others, the particular words just may not "catch on". The point is that choosing meaningful and acceptable words to convey the general principles and to pinpoint specific concepts is an important aspect for planning for change and preparing for new ways of thinking (p. 653).

Finally, a modicum of humility is an inevitable result of applying the robust techniques of the laboratory to the natural environment.

Behavior treatments are precise, demanding and difficult behavior change techniques that require the behavior modifier to have substantial
control over the environment. The usefulness of behavior modification techniques in natural settings is often quite limited because even minimal conditions necessary for behavior change are difficult to obtain (p. 659).

This treatment program, or for that matter most any conceivable behavior treatment program, will modify only a portion of the client's behavior and environment. Hopefully, it is constructed to optimally effect change so that abusive drinking is decreased. Even so, it is not a panacea, or a universal treatment. It is instead a novel and promising attempt to alleviate the incidence of a serious problem in American society.
APPENDICES

A. MIADS Logo
B. Daily Alcohol Intake Sheet
C. MOBAT
D. Marlatt Drinking Profile -- Pre & Post Treatment Form
E. Marlatt Drinking Profile -- Follow-up Form
F. Social Adjustment Indices
G. Social Adjustment Indices -- Scoring Criterion
H. Chart for recording treatment progress from AIS Data
I. Chart for recording treatment progress from MOBAT Data
J. Chart for recording treatment progress from SAI Data
K. Personal Agreement Form
L. Treatment Summary Form
Appendix A

MIADS Logo

Used on all treatment forms given to clients
Appendix B.

Daily Alcohol Intake Sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Drink (Describe Beer, Wine, Type of Mixed Drink, or Whiskey)</th>
<th>Time Drink First Ordered</th>
<th>Number of Sips Per Drink</th>
<th>Amount of Alcohol in Each Drink (Number of Ounces)</th>
<th>Where Drinking Occurred (Bar, Home, etc.)</th>
<th>Whom Were You With When you Drink</th>
<th>Did You Refuse Any Drinks You Were Offered? (YES/NO)</th>
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* Each drink consumed goes on a new line. If no alcohol was consumed on a day under type of drink write the word NONE.
Appendix C.

MOBAT

Cf. Sobell and Sobell, 1975 for a thorough description.
Appendix D.
Marlatt Drinking Profile

From Marlatt, 1976, pp. 124-137.
DRINKING PROFILE

Name of Patient: ____________________________ (First) (Initial) (Last)

Interviewer: _______________________________ Date: _____________

Instructions to Patient

Your answers to the following questions are needed in order to assist us in planning your treatment program. Please try to answer each question as accurately as possible. If you have trouble understanding any questions, feel free to ask for further information.

I. IDENTIFICATION MATERIAL

A. Age and Residence

1. Present Age: _____ Date of Birth: _______ Day Month Year

2. Local (present) Address: __________________________________________

   Local Telephone: __________________________

3. Permanent Address (if different from No. 2 above): ___________________

   Permanent Telephone: __________________________

   Area Number

4. Name and address of a person through whom you can always be reached (should be different from No. 3 above):

   ___________________________________________________________________

   Telephone: __________________________

   Area Number
Drinking Profile: 2

5. Were you referred to this hospital by a doctor or other professional person?

__Yes __No (If yes, specify whom) ______________________

(Name)

(Title or Position) (Building Title [clinic, department, etc.])

(Street Address or Box No.)

(City or Town) (State) (Zip Code)

Telephone: ______________________

Area Number

B. Family Status

1. Patient's Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed

(If Married) Spouse's Name: ________________ (First Name) ________________ (Middle Name)

Is your spouse currently living with you? ___Yes ___No

Address (if different from patient's local address): ______________________

Telephone: ______________________

Do you have any children? ___Yes ___No

(If yes, list name, sex, and ages of children): ______________________

2. List other individuals living at the patient's current residence (use other side if necessary):

Name: ______________________ (Last) (Initial) (First)

Age: ___ Sex: ___ Relationship: ______________________
C. Employment and Income Information

1. Major occupation or skill (whether or not presently employed): __________

2. Title of present job (major job, if more than one): __________________________
   __unemployed, __self-employed

3. Name of employer or supervisor: ____________________________
   (Last) (Initial) (First)

   Name and address of firm or company (if applicable): ______________________
   _____________________________________________________________________

   Telephone: ________________

4. Average monthly income from this job: $______________

5. Length of time in present job: ________ (Years) _________ (Months) ________ (Weeks)

6. Additional monthly income (list amounts and sources):
   ___________________________________________________________________
   Total Monthly Income: $__________

7. How many different jobs have you held in the past year? ______________
   In the past five years? ____________

D. Educational History

1. Did you graduate from high school or equivalent? __Yes __No
   If No, what was the highest grade attained in school? ______________________

2. Did you attend a college or university? __Yes __No
   If Yes, what was the highest year attained in college? ______________________
   Major Subject: ____________________________ Degree (if any): ______________

3. List any further educational training (specify nature of training and degrees obtained):
   ____________________________________________________________________
II. DRINKING PATTERNS

A. Development of the Drinking Problem

1. Approximately how old were you when you first took one or more drinks? ___

2. Approximately how old were you when you first became intoxicated? ____
   Do you remember what you were drinking at that time? Beverage: ____________

3. How would you describe the general drinking habits of each of your parents?
   The categories are: Non-drinker, occasional light social drinker, moderate to average social drinker, heavy and frequent social drinker, and alcoholism problem. Which category best suits your Father (or guardian)? Your Mother? (Check categories below)

   **FATHER**
   ___ Not applicable
   ___ Non-drinker (abstinent)
   ___ Occasional or light Social Drinker
   ___ Moderate or average Social Drinker
   ___ Frequent or heavy Social Drinker
   ___ Alcoholism Problem

   **MOTHER**
   ___ Not applicable
   ___ Non-drinker (abstinent)
   ___ Occasional or light Social Drinker
   ___ Moderate or average Social Drinker
   ___ Frequent or heavy Social Drinker
   ___ Alcoholism Problem

4. Approximately how old were you when drinking first became a "real problem" for you; that is, when drinking began to have an effect on your life which you did not really approve of? ___ Age ___ Denies that it is a "real problem".

   At that particular time in your life, when drinking first became a real problem, were there any special circumstances or events which occurred which you feel were responsible for it becoming a problem? (If Yes, summarize circumstances): ________________________________________

5. Before drinking became a real problem for you, how would you describe your drinking habits? (Attempt to fit the reply into one of the categories below):

   ___ Cannot say
   ___ Non-drinker or abstinent
   ___ Occasional or light Social Drinker
   ___ Moderate or average Social Drinker
   ___ Frequent or heavy Social Drinker
   ___ Other (Specify: ________________________________)

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Drinking Profile: 5

B. Usual Drinking Pattern

1. What would you say best describes your overall drinking habits? Would you say that you were a periodic, intermittent drinker (one who drinks heavily on a binge or drinking bout every so often, with periods of little or no drinking between binges), or a steady, regular drinker (one who continuously drinks more or less the same amount on a day-to-day basis)?

___ Periodic ___ Steady ___ Cannot say (or "both")

a) Section for Periodic Drinkers and Cannot Say Group

About how many drinking bouts have you had in the past six months? ___

About how long does your average drinking bout usually last? ___ Hours ___ Days

What is the longest bout you have ever had? ___ Hours ___ Days

On the average, how much time goes by between drinking bouts?

___ Days ___ Weeks ___ Months

How would you describe the circumstances which mark the end of one of these drinking bouts? That is, what factors determine when you finally stop drinking? ____________________________________________________________

b) Section for Steady Drinkers and Cannot Say Group

Are there any particular days of the week during which you drink more than on other days? ___Yes ___No (list days if Yes): ______

C. Factors Associated with Drinking

1. Do you sometimes take a drink in the morning, before breakfast? ___Yes ___No

2. Do you find that you are unable to stop drinking, once you have had one or two drinks on any occasion? ___Yes ___No

If Yes: Why do you think you are unable to stop after the first one or two drinks? ____________________________________________________________

3. After drinking for a period of time, have you ever had any of the following experiences? (check for positive reply)

___ A hangover
___ Nausea and/or vomiting
___ An episode of the "shakes"
___ A "blackout" (lapse of memory for events which occurred while drinking)
___ Vague feelings of fear and anxiety

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Drinking Profile: 6

_____ A convulsion or seizure
_____ The "D.T.'s" (when you saw, felt, or heard things that were not really there)

Is there anything else that happens to you after drinking? (If Yes, specify)

___________________________________________________________

4. Has drinking, in your opinion, been the cause of any of the following events in your life? (Check for positive reply)

_____ Losing a job or jobs
_____ Getting arrested
_____ Becoming divorced or separated
_____ Losing a personal friend or friends
_____ Being broke or in financial debt
_____ Having a serious medical problem (Specify):

___________________________________________________________

D. Periods of Abstinence

1. Since drinking first became a real problem for you, what is the longest period of time during which you did not take a drink?

_____ Days  _____ Weeks  _____ Months  _____ Years  _____ Never abstinent

When did this period end?  _____ Month  _____ Year

a) What would you say was the main reason or reasons for stopping drinking at that time? ______________________________________________________

b) What would you say was the main reason or reasons for starting to drink again after this period? ______________________________________________

2. Have you had a period of abstinence or non-drinking during the past six months?  _____ Yes  _____ No (Specify duration): ____________________________

a) What would you say was the main reason for stopping drinking at that time? ______________________________________________________

b) What would you say was the main reason for starting to drink again after this period? ______________________________________________

E. Drinking Setting

1. Card sort instructions: Drinking Locations

I am going to give you a set of cards, each of which has a place or setting written on it where drinking might occur. I want you to do two things with this set of cards.
First, I want you to sort the cards into two piles: place those cards in one pile, here on the left, if they list places where you have done at least some of your drinking in the past six months or so; if they list places where you have done no drinking in the past six months, then place them in the other pile on the right. Any questions? All right, begin sorting the cards.

(Wait until first sorting is complete)

Secondly, I want you to take the pile on your left, and arrange the cards in order of where you have done most of your drinking in the past six months. Put the one card on the top which lists the place where you do most of your drinking, and then sort the rest of the cards to represent places where you do relatively less and less drinking. The card on the bottom should list the place where you do the least drinking of all.

(Indicate below, the ordering of the second card sort)

____ Tavern or bar (if selected, ask which bar is the favorite; location of bar; and name of bartender, if known):

Name of bar: ________________________________

Location (city or town): ____________________________

Name of bartender, if known: ____________________________

____ Restaurants (with meals)
____ In your own home
____ In other people's homes
____ At work
____ Private club or social fraternity
____ Social events (such as weddings, parties, dances)
____ While driving
____ Out of doors

List any additional places, if mentioned: ____________________________

2. Card sort instructions: Social Settings

Now, I am going to ask you to do the same sort of thing with another set of cards. These cards have various persons listed on them, whom you may or may not drink with at various times.

Again, I would first like you to sort the cards into two piles: place those cards in a pile on the left, if they list a person or persons with whom you have done at least some of your drinking in the past six months or so; if they list a person or persons with whom you have done no drinking in the past six months, then place them in the other pile on the right. Any questions? All right, begin sorting the cards.

(Wait until first sorting is complete)
Drinking Profile: 8

Secondly, I want you to take the pile on the left, and arrange the cards in order of the people listed with whom you have done most of your drinking in the past six months. Put the one card on the top which lists the person or persons with whom you do most of your drinking; and then sort the rest of the cards to represent people with whom you do relatively less drinking. The card on the bottom should list the person or persons with whom you do the least drinking of all.

(Indicate below the ordering of the second card sort)

<table>
<thead>
<tr>
<th></th>
<th>I drink alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>I drink with my wife (or husband)</td>
</tr>
<tr>
<td>___</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>I drink with relatives other than my wife (or husband)</td>
</tr>
<tr>
<td>___</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>I drink with a male friend or friends (no females present)</td>
</tr>
<tr>
<td>___</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>I drink with a female friend or friends (no males present)</td>
</tr>
<tr>
<td>___</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>I drink with friends of both sexes</td>
</tr>
<tr>
<td>___</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>I drink with strangers, or people I meet after I have started drinking</td>
</tr>
</tbody>
</table>

F. Associate Behaviors

1. Do you smoke?  ____Yes  ____No  (If Yes, how much do you smoke a day):
   - Heavy (more than two packs)
   - Moderate (1-2 packs)
   - Light (less than one pack)
   - Pipe or Cigars

2. Do you like to gamble?  ____Yes  ____No  (If Yes, what type of gambling do you prefer?)

3. Do you have any interests, hobbies, or other pastime activities that take up some of your free time, and that are not connected with your drinking?  (List):

III. ATTITUDES AND PREFERENCES

A. Preferences and Rates

1. Card Sort Instructions: Beverage Preferences

Now, I am going to give you another set of cards, with various kinds of alcoholic beverages printed on them. Here, we are interested in getting an idea of what your favorite drinks would be, if you were in the mood for drinking.

a) First, I want you to look at the cards, to get an idea of the overall selection. Then, I want you to sort the cards into two piles: place those cards in a pile on the left, if they list a beverage which you would like to drink, if you were in the mood to drink and were given a free choice of selection. Pay no attention...
Drinking Profile: 9

to the price or availability of each drink; we want your ideal preferences for drinks—as if you had a choice to select whatever you wanted from a liquor store, without worrying about money.

Put the cards in a pile on the right if they list a beverage which you do not like to drink, when you are given a free choice of selection. Any questions? All right, begin sorting the cards.

(Wait until first sorting is complete)

Now I want you to take the pile on the left, and arrange the cards in order of your favorite choices. Put the one card on the top which lists your most favorite beverage, if you had a free choice of what to drink. Then sort the rest of the cards to represent your second, third, and fourth choices, and so on through the pile. The card on the bottom should list your least preferred choice.

(Indicate on the main list, in the left column, the ordering of preferences. Then take the first three preferred beverages, and obtain the favorite brand, if any; and the manner in which the subject prefers to drink each--i.e., with or without mixer, ice, etc. Specify brand names, if possible, for mixers. List this information immediately below.)

(i) First Choice Beverage: _____________________ Brand: ______
    Preferred Manner of Drinking: ______________________________

(ii) Second Choice: _____________________________ Brand: ______
    Preferred Manner of Drinking: __________________________

(iii) Third Choice: _____________________________ Brand: ______
    Preferred Manner of Drinking: ______________________

b) OK, now I want you to go through all the cards a second time. First, I want you to again sort the cards into two piles: place those cards in a pile on the left, if they list a beverage which you actually do drink, from time to time. For many people, the drink they would pick as their favorite beverage may not be the one they actually drink the most, due to reasons of cost and so forth. So, put those cards in the left pile which list beverages which you actually do drink in more or less amounts on different occasions. Put those cards in a pile on the right if they list a beverage which you never have drunk, as far as you can remember. Any questions? All right, begin sorting the cards.

(Wait until first sorting is complete)
Secondly, I want you to take the pile on the left, and arrange the cards in order of how frequently or how often you drink each beverage. Put the one card on the top which lists the beverage which you actually drink the most of all. Then sort the rest of the cards to represent which beverage you drink second most often, third most often, and so on, through the pile. The card on the bottom should list the beverage which you drink least frequently of all.

(Indicate on the main list, in the right column, the ordering of cards. Then take the first three most frequently consumed beverages, and ascertain the brand most frequently consumed, and the preferred manner of drinking, as before. List this information immediately below.)

(i) Most Frequently Consumed Drink: _______ Brand: _______
   Preferred Manner of Drinking: ____________________________

(ii) Second Beverage: ___________________________ Brand: _______
   Preferred Manner of Drinking: ____________________________

(iii) Third Beverage: _________________________ Brand: _______
   Preferred Manner of Drinking: ____________________________

BEVERAGE LIST

<table>
<thead>
<tr>
<th>Preference</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blended Whiskey</td>
</tr>
<tr>
<td></td>
<td>Bourbon</td>
</tr>
<tr>
<td></td>
<td>Brandy</td>
</tr>
<tr>
<td></td>
<td>Gin</td>
</tr>
<tr>
<td></td>
<td>Rum</td>
</tr>
<tr>
<td></td>
<td>Scotch Whiskey</td>
</tr>
<tr>
<td></td>
<td>Tequila</td>
</tr>
<tr>
<td></td>
<td>Vodka</td>
</tr>
<tr>
<td></td>
<td>Liqueur</td>
</tr>
<tr>
<td></td>
<td>Beer and/or Ale</td>
</tr>
<tr>
<td></td>
<td>Malt Liquor</td>
</tr>
</tbody>
</table>
Drinking Profile: 11

<table>
<thead>
<tr>
<th>Preference</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Red Dry Wine</td>
</tr>
<tr>
<td></td>
<td>Red Sweet Wine</td>
</tr>
<tr>
<td></td>
<td>White Dry Wine</td>
</tr>
<tr>
<td></td>
<td>White Sweet Wine</td>
</tr>
<tr>
<td></td>
<td>Sparkling Wine or Champagne</td>
</tr>
<tr>
<td></td>
<td>Special Fortified Wine (20% alcohol)</td>
</tr>
<tr>
<td></td>
<td>Non-beverage Alcohol (e.g., shaving lotion)</td>
</tr>
<tr>
<td></td>
<td>Other (Specify): ______________</td>
</tr>
</tbody>
</table>

2. What are your three favorite non-alcoholic beverages? (Specify brand, if possible)

   First Choice: ____________________________ Brand: __________
   Second Choice: ____________________________ Brand: __________
   Third Choice: ____________________________ Brand: __________

3. We are also interested in the amount of alcoholic beverages you consume, on the average. For this reason, we would like you to estimate the average amount of alcohol you drank in a given time period.

   a) During an average day when you are drinking, how much do you drink? (Try to get specific units: number of bottles or cans of beer; pints or fifths of hard liquor, etc. Use other side, if necessary.)

      Beverage: ____________________________ Amount: __________
      Comments: ____________________________
      (and others)

   b) During an average week when you are drinking, how much do you drink?

      Beverage: ____________________________ Amount: __________
      Comments: ____________________________
      (and others)
c) (For periodic drinkers only) About how long did your last drinking bout last? ___Days ___Hours

When did this bout start, approximately? ___Day ___Month ___Year

About how much alcohol did you drink at that time?

Beverage: ___________________________ Amount: _________

Comments: __________________________________________________________
(and others)

4. Approximately how much do you spend on alcoholic beverages when you are drinking?

   Per day? $__________
   Per week? $__________

B. Reasons for Drinking

1. In your own words, what is the main reason why you drink?

2. Are there any other reasons why you drink, which you consider important? If Yes, what are they?

3. Do you have inner thoughts or emotional feelings, or things within you as a person, which "trigger off" your need or desire to take a drink at a particular moment in time?

4. Are there any particular situations or set of events, things which happen to you in the outside world, which would be most likely to make you feel like having one or more drinks?

5. Can you describe a situation or set of events which would be least likely to make you feel like drinking? In other words, when do you least feel like drinking?
Drinking Profile: 13

6. When you are actually drinking, what, for you, is the most positive or desirable effect of alcohol? In other words, what is the thing you like best about alcohol when you are drinking?

Are there other positive or desirable effects which you get while you are actually drinking?

In terms of your life as a whole, what do you see as the most positive effects or consequences of your drinking behavior?

7. When you are actually drinking, what, for you, is the most negative or undesirable effect of alcohol? In other words, what is the thing you like least about alcohol when you are drinking?

Are there other negative or undesirable effects which you get while you are actually drinking?

In terms of your life as a whole, what do you see as the most negative effects or consequences of your drinking behavior?

8. Card Sort Instructions: Effects of Drinking

We are interested in knowing more about what kinds of effects alcohol has on you when you are drinking. I am going to give you another set of cards, with different possible effects of drinking written on them. I would like you to sort these cards into two piles. Place those cards in a pile on the left, if they describe effects that alcohol has on you when you are actually drinking. Put the cards in a pile on the right which list effects which you do not get from alcohol when you are drinking. Any questions? All right, begin sorting the cards.

<table>
<thead>
<tr>
<th>Positive Effects:</th>
<th>Negative Feelings:</th>
<th>Negative Feelings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension Reduction</td>
<td>Anger/Frustration</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Happy</td>
<td>Angry</td>
<td>Afraid</td>
</tr>
<tr>
<td>Relaxed</td>
<td>Sad</td>
<td>Nervous</td>
</tr>
<tr>
<td>Peaceful</td>
<td>Depressed</td>
<td>Tense</td>
</tr>
<tr>
<td>Calm</td>
<td>Lonely</td>
<td>Excited</td>
</tr>
<tr>
<td>Unafraid</td>
<td>Frustrated</td>
<td>Restless</td>
</tr>
</tbody>
</table>
Drinking Profile: 14

Positive Feelings:
Socially Outgoing and
Positive Self-esteem

Negative Feelings:
Socially Withdrawn and
Negative Self-esteem

___ Secure
___ Superior
___ Outgoing
___ Friendly
___ Strong

___ Insecure
___ Inferior
___ Withdrawn
___ Unfriendly
___ Weak

(Spread out chosen list of effects in front of subject)

Now, looking at these cards you have chosen, I want you to pick out the five cards which represent the five most accurate descriptions of effects which are true for you when you are drinking. (Wait until subject picks the five cards) OK, now would you please arrange these five cards in order from the most true effect for you to the least true effect of the five cards. Put the one card listing the most true effect on the top, and the card with the least true effect on the bottom, with the other three cards arranged in the middle in terms of how accurately they describe effects which you get from drinking. Any questions?

(List the five cards in order of accuracy, below)

Comments, if any:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

C. Motivational Aspects

1. On your own, and without any outside help, what steps, if any, have you taken in an attempt to stop drinking?

2. Have you previously sought outside help, professional or otherwise, for your drinking problem? ___Yes ___No

(If Yes, ask the subject to specify the nature of this help, as indicated below.)

Date: ________________ Nature of Contact: __________________________

Results: ________________________________________________________

(and others)
Drinking Profile: 15

3. Have you ever taken the drug, Antabuse? ___Yes ___No
   (If Yes, specify dates): From __________ to __________
   From __________ to __________

4. Are you now a member of A.A. (Alcoholics Anonymous)? ___Yes ___No
   If Yes, when did you first join? Date: __________________________
   If No, have you ever been a member of A.A. in the past? ___Yes ___No
   Specify dates, if Yes: From __________ to __________

5. What are the main reasons for seeking help for your drinking at this particular time? In other words, what circumstances led to your coming to this hospital at this time?

6. a) What do you see as the most ideal outcome of treatment here for you? In other words, what would you consider to be the most desirable outcome of treatment in your case?
   
   In your honest and realistic opinion, what do you estimate your chances are from 1 to 10 of obtaining this outcome? __________

   b) What is most likely to happen in your case, if this ideal outcome of treatment does not occur?

7. Card Sort Instructions: Treatment Outcome

   I am going to show you four cards, listing different possible outcomes of treatment for alcohol problems. I want you to arrange them in an order representing your preferences for what you would like as the eventual outcome of treatment at the top of the pile, and the least preferred outcome at the bottom.

   (Number the order of preference below)
   _____ I would like to stop drinking completely.
   _____ I would like to become an occasional (light) social drinker.
   _____ I would like to become a moderate (average) social drinker.
   _____ I would like to become a heavy (frequent) social drinker.
8. In your own words, how would you define alcoholism?

9. Some people have said that alcoholism is a disease or sickness, while while others have said that it is not a disease, but rather it is more like a bad habit a person has learned. Do you see it more as a disease or a bad habit?

____ Disease  ____ Bad Habit

10. Would you say that you are an alcoholic?  ____ Yes  ____ No

Comments:  

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Appendix E.

Marlatt Drinking Profile -- Follow-Up Form

Provided by G. Alan Marlatt
DRINKING PROFILE: FOLLOW-UP QUESTIONNAIRE

Name: __________________________ Date: __________ Interviewer:________

Contact:____ Telephone____ Mail____ Personal (Place: ________________ - )

Instructions

With research in the area of alcoholism, many treatment methods have not been too successful. In attempting to provide information which will help doctors and other scientists improve their methods of treatment, we need certain information from people such as yourself. As you have undergone certain treatment procedures, we need this information for use in improving future programs in the treatment of alcoholism.

For these reasons, we urge you to be completely honest in your answers to the questions which follow. If you have resumed drinking again, please do not feel ashamed to tell us about it. What will help us the most are honest answers—regardless of whether they show the treatment program to be a success or a failure. This is the only way in which we can make changes in the program so as to help other people who may receive it in the future. All information obtained on this Questionnaire will be held in strict confidence—no information will be released to any outside individual or agency under any circumstances.

PART I All individuals are to answer the following questions.

1. Local (present) address: ___________________________________________

   Street Address or Box No.

   City or Town                         State                         Zip Code

   Local telephone number:

   Area Number

2. Permanent address (if different from above):

   Miss
   c/o Mrs.
   Mr.

   Last Name       Initial       First Name

   __________________________

   Street Address or Box No.

   City or Town                         State                         Zip Code

   Permanent telephone number:        Area Number

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Part I (Continued)

3. Are you working at a job now? (Check One): ___Yes ___No
   a) If you are working now, briefly describe the nature of your job
      (title of job, description of duties, etc):

   b) What is your average monthly income from this job? $_________

   c) What length of time have you been working on this job?

      Years   Months   Weeks

4. What is your present marital status? (check one):

      ___Single   ___Married   ___Divorced   ___Separated   ___Widowed

5. Please indicate below the person or persons who are now living with
   you at your present address. (Check the appropriate space in the
   column at the left, and indicate the person’s name in the appropriate
   space on the right.)

<table>
<thead>
<tr>
<th>Check if applicable</th>
<th>Now Living With</th>
<th>Indicate Name of Person(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I live alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse or Living-Mate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter or daughter-in-law:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son or son-in-law:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Relative:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other. Give name and the nature of relationship:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you are now living in a mission center, half-way house, boarding
home, hotel, or rented apartment or house, please indicate the name
of the landlord or supervisors:
Part I (continued)

6. Are you now an active member of Alcoholics Anonymous?  ____Yes  ____No.

7. Please briefly describe, in the space below, what you remember about the type of treatment program you received at the Alcoholism Treatment Center:

8. Have you consumed any alcoholic beverages at all since you left the hospital?  ____Yes  ____No (Check one)

   Note  If your answer to this Question (No. 8) is Yes, please fill out Part II of this Questionnaire, listed immediately below. If your answer to this Question is No, skip Part II, and go on to fill out Part III on Page 6.

Part II  To be filled out only by those individuals who have had at least one drink since leaving the hospital.

1. a) I took my first alcoholic drink approximately ____days after leaving the hospital. (Fill in the number of days between leaving the hospital and having the first drink.)

   b) The approximate date when I took my first alcoholic drink after leaving the hospital was: ___________ ___________ ___________ (fill in date).

   Month  Day  Year

2. List the type of alcoholic beverage you consumed as the first drink (be specific, if possible, as to type and brand of drink; for example, Seagram's 7 whiskey, or Budweiser beer, etc.)

   Beverage: ______________  Brand: ______________  Type: Beer, whiskey, gin, etc.

3. Briefly describe, in the space below, the situation in which you took your first drink. Indicate the specific information asked for, and describe the situation (in which you took your first drink) in your own words:

   When I took my first drink, the situation was as follows:

   a) Time of day: ______________________________________________
Part II (continued)

b) Place (at home, in a bar, or wherever): ____________________________

c) List other people who were present with you at that time: ________________


d) When I took my first drink, the situation was as follows (briefly describe the important features of the situation which led you to take the first drink):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________


e) What would you say was the main reason for taking that first drink?
____________________________________________________________________
____________________________________________________________________


f) Describe any inner thoughts or emotional feelings (things within you as a person) which "triggered off" your need or desire to take the first drink at that time:
____________________________________________________________________
____________________________________________________________________


g) Describe any particular circumstances or set of events, things which happened to you in the outside world, which "triggered off" your need or desire to take the first drink at that time:
____________________________________________________________________
____________________________________________________________________


4. After having that first drink, did you consume more alcoholic beverages on the same occasion? __Yes __No. (Check One).

Note: If the answer to this Question is Yes, continue with the remaining of Question No. 4; if your answer is No, go on to Question No. 5.
Part II (continued)

4. a) How much more alcohol did you drink on that occasion? (list brand and type of beverage and approximate amount consumed of each):

<table>
<thead>
<tr>
<th>Beverage</th>
<th>Brand</th>
<th>Type</th>
<th>Amount Consumed</th>
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b) Approximately how long did this drinking episode last? ___ Days _____________

c) Did you drink until you became intoxicated? ____Yes ____No (check one)

d) Did you drink until you passed out? ____Yes ____No (check one)

5. Since leaving the hospital, were there other times (in addition to the first time) when you drank alcoholic beverages? ____Yes ____No (check one)

NOTE: If the answer to this question is Yes, continue with the remaining parts of Question No. 5, if your answer is No, go on to Question No. 6.

a) Would you describe these additional drinking periods as drinking "binges," or have you been drinking "steadily" on a day-to-day basis? ____Drinking "binges" ____Steady drinking (check one).

If you checked "Drinking Binges" please answer the following 2 questions

i) Since leaving the hospital, approximately how many binges have you had? ________________Number of binges.

ii) About how long do each of these binges last? ___ Hours _____

If you checked "Steady Drinking" please answer the following questions:

i) How many drinks do you have on an average day? (Specify brand and type of beverage, and amount consumed.)

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<th>Beverage</th>
<th>Brand</th>
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6. When did you last take an alcoholic drink? I last took a drink ___

Days ___

Hours ___
Follow-Up Questionnaire  Page 6

Part II (continued)

7. Are you now in any form of treatment for your drinking problems?  
   Yes  No. If you answered Yes, indicate briefly the nature of  
   this treatment program:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Part III To be filled in only by those individuals who have not consumed any  
   alcoholic beverages since leaving the hospital.

1. Were you tempted to take a drink at any time since leaving the hospital?
   Yes  No
   If the answer to this question is Yes, please briefly describe the  
   factors or reasons why you were able to resist the temptation to drink.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. Briefly describe what you think is the one main reason or factor that  
   has helped you most in staying sober (or not drinking) since leaving  
   the hospital.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Important Note

Thank you for your help in obtaining this information concerning your  
   current drinking practices. The information you have provided will be kept  
   in strict confidence. If you have any further comments or suggestions which  
   may be of help to us in conducting this project, please note them on the  
   back of this page. Please sign your name and the date when this form was  
   completed. Place the Questionnaire in the enclosed self-addressed return  
   envelope, and mail it at your earliest convenience.

   ____________________________________________________________
   Signature Date of Signature
Appendix F.

Social Adjustment Indices
1. How would you say you are doing right now, that is, how well are you getting along with people and meeting the day to day problems of everyday life?
   ____ very well  ____ well  ____ OK  ____ not too well  ____ poorly

2. Have you changed jobs in the past few weeks?
   How are you employed right now?
   How many hours did you work last week?
   Has the boss said anything to you about your work?
   If he has, what?

3. Check the one which is true of you.
   ____ full time worker  ____ part time
   ____ student  ____ on welfare  ____ retired  ____ physically disabled
   ____ unemployed

4. What is your current address?

   How long have you lived there?
   How often do you pay rent? (or make payments)
   How many days in the past 2 months have you spent in the hospital
   In jail?

5. Do you currently have a valid Montana driver's license?

6. Are you married right now?

7. Have you seen anybody for help with your drinking lately?

8. Do you still have the papers we gave you at the end of the group?

9. How is your health?

10. How many days in the past month have you gone without drinking?

11. How many days in the past month have you had some alcohol, but not been drunk?
Appendix G.

Social Adjustment Indices Scoring Criterion


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1. **General Adjustment** (to interpersonal relationships and problem situations):
   +1=improved
   0=same
   -1=worse

2. **Vocational Status**:  
   Improved same worse  
   +1 0 -1
   a. changes in employment  
   b. number of hours worked  
   c. Supervisor's comments

3. **Occupational Status**:  
   7=full time  
   6=part time  
   5=student or apprentice  
   4=retired  
   3=welfare  
   2=physically disabled  
   1=unemployed

4. **Residential Status & Stability Index**:  
   \[ I = (L_i \times S_i) \]
   Opportunity to reside
   Where:
   L_i=1 if current residence was same for six or more months  
   L_i=2 if current residence was same for four to six months  
   L_i=3 if current residence was same for one to four months  
   L_i=4 if current residence was same for less than one month  
   S_i=1 if residence is permanent—rent or regular payment  
   S_i=2 if residence is transitional—provided by agency  
   S_i=3 if residence is transient—living on own with weekly payment  
   Opportunity to reside = 1—proportion of follow-up interval  
   (180 days) in jail, hospital
   Improved same worse  
   +1 0 -1

5. Have valid driver's license?  
6. Married?  
7. In therapy?  
8. Possess treatment materials?  
9. Physical health?  
10. Factor success: a. Abstinent or controlled drinking 75%
(135 days).

b. Improved on general adjustment
c. Improved on vocational status
   =1 if one is present at follow-up
   =2 if two are present at follow-up
   =3 if three are present at follow-up
Appendix H.

Chart for Recording Treatment Progress Using AIS data
Client's Name________________

Date of Treatment__________

Treatment Center___________
Appendix I.

Chart for Recording Treatment Progress Using MOBAT data
Appendix J.

Chart for Recording Treatment Progress Using SAI data
# Social Adjustment Indices

<table>
<thead>
<tr>
<th>Follow-up #1</th>
<th>Follow-up #2</th>
<th>Follow-up #3</th>
<th>Follow-up #4</th>
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Client's Name

Date of Treatment

Treatment Center
Appendix K

Personal Agreement Form

I hereby agree with myself as an American Indian and a representative of my tribe that:

1. On an average day I will not have more than ___ drinks (regular limit).

2. On an average week I will not have more than ___ drinks (weekly limit).

3. On any occasion I will not have more than:
   ___ drinks in 1 hour
   ___ drinks in 2 hours
   ___ drinks in 3 hours
   ___ drinks in 4 hours

4. I will actively participate in this program for eight weeks, and will fill out forms afterward to let the group leaders know how I'm doing.

__________
Signed

__________
Date
Appendix L

Treatment Summary Card

I will:
1.
2.
3.
4.
5.
6.
7.

I will not:
1.
2.
3.
4.
5.
6.
7.

(To be accumulated individually for each client from his/her Marlatt Drinking Profile).
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