Chapter 8—Measuring Components of Client Motivation

Motivation is multidimensional, not a single domain that can be easily measured with one instrument or scale. This chapter describes a variety of tools for measuring the building blocks of motivation discussed throughout this TIP. This chapter should be regarded as a progress report because concepts of motivation for change are evolving, and new approaches for assessment are being tested. Measures often have to be adapted, and their psychometric characteristics change when they are applied to new problems and populations. There are also specificity challenges in assessing motivation. For example, clients are often at very different points of readiness with regard to different substances. A person may be in the action stage for cocaine, the contemplation stage for alcohol, and the precontemplation stage for marijuana and tobacco. No doubt, motivation measures will become more precise in the years ahead.

In this chapter is a set of measures endorsed by the Consensus Panel. For most measures, there is good psychometric documentation, but some are at earlier stages of validation. Most have not been normed for different racial or ethnic groups. Many clinicians have found these formal tools to be valuable and appreciate the structure and focus these instruments can provide—the sense that their work with the client is task-centered and grounded in reality. The results also provide one more type of feedback to use with clients throughout the change process to enhance motivation. For some clients, test scores add a dimension of objectivity to the counseling situation, which may otherwise seem highly subjective. One risk to be aware of in using these tools, however, is that some clients might focus too heavily on scores indicating their vulnerabilities rather than on those indicating their strengths.

This chapter offers ways of measuring the following dimensions of motivation:

- Self-efficacy
- Readiness to change
- Decisional balancing
- Motivations for using substances
- Goals and values

The purpose of this chapter is to aid you in assessing where clients are in terms of motivation levels and also to help you apply the motivational principles and appropriate strategies for different stages of change that are discussed in Chapters 4 through 7. A variety of valuable and psychometrically sound instruments and scales that are easy to administer are now available (Allen and Columbus, 1995). You may wish to try several different instruments to find those that work best with your clients, that measure the dimensions of most interest to you, and that match your clinical style. Many of the instruments discussed in this chapter appear in Appendix B.

Self-Efficacy

Individuals in recovery have very different levels of confidence regarding their ability (self-efficacy) to change and abstain from substances. Some are overly confident, while others feel hopeless about achieving sobriety or even reducing use. Self-efficacy, particularly with respect to capabilities for overcoming alcohol dependence or abuse, is an important predictor of treatment outcome (DiClemente et al., 1994). Because certain situations are more likely to lead to setbacks for those in recovery (Marlatt and George, 1984), identifying these high-risk situations is an important step in treatment.

Self-efficacy questionnaires ask clients to rate how risky certain situations are and to estimate their confidence in how well they would do in avoiding the temptation to use substances in these situations. The numerical scores provide an objective measure of a client's self-efficacy for a specific behavior over a range of provocative situations. Some computerized versions of these instruments generate small bar graphs that add a visual dimension to the numbers. By using these tools, clients gain an understanding of where their individual risks lie—high-risk situations in which they have low self-efficacy. This information can be extremely useful in setting realistic goals and developing an individualized change plan and can provide a sound basis for self-monitoring.
Clients who rank many situations as high risk (i.e., low self-efficacy) may need to learn new coping strategies.

**Situational Confidence Questionnaire**

The Situational Confidence Questionnaire (SCQ) has been used specifically with those who drink heavily. The instrument consists of 100 items that ask clients to identify their level of confidence in resisting drinking as a response to the following eight types of situations (Marlatt and Gordon, 1985):

1. Unpleasant emotions
2. Physical discomfort
3. Testing personal control over substance use
4. Urges and temptations to drink
5. Pleasant times with others
6. Conflicts with others
7. Pleasant emotions
8. Social pressure to drink

Clients are asked to imagine themselves in each situation and rate their confidence on a 6-point scale, ranging from not at all confident (a rating of 0) to totally confident (a rating of 6) that they can resist the urge to drink heavily in that situation. The SCQ generally takes about 20 minutes to complete, using either pencil and paper or computer software that automatically scores answers and generates a profile of the client's alcohol use. The SCQ is accompanied by an Inventory of Drinking Situations that assesses the frequency of heavy drinking in different situations. The results of this questionnaire can be used to provide personalized feedback to the client as well as for treatment planning (Annis and Davis, 1991). High confidence scores have been shown to predict positive treatment outcomes (Annis and Davis, 1988), whereas low confidence scores have identified clients who are likely to have poor treatment outcomes (Sobell et al., 1997). An amended version of the SCQ, the SCQ-39, is the version recommended by the questionnaire's developer (see Appendix B).

**Brief Situational Confidence Questionnaire**

The Brief Situational Confidence Questionnaire (BSCQ) was developed as an alternative to the SCQ because some treatment programs found the length and scoring and graphing systems of the original instrument to be too time-consuming in clinical practice (Sobell, 1996). The eight items of the BSCQ, reproduced in Appendix B, correspond to the eight subscales in the original SCQ. Respondents in a community study (Sobell et al., 1996b) were asked to rank their confidence at the time of taking the questionnaire in resisting using alcohol or a primary drug in each situation on a scale from 0 (not at all confident) to 100 (totally confident). A comparison of the brief and long versions of the SCQ (Breslin et al., 1997) found that the shorter version is also effective and corresponds well with the longer version on most subscales. The BSCQ, although not as comprehensive and not yet as extensively tested, has several clinical advantages over the longer version. It can be administered in a few minutes, is easily interpreted by clinicians, provides immediate feedback for the client, and can be used easily in primary care and other nonaddiction-specific settings (Breslin et al., 1997). The BSCQ is also available in Spanish.

**Alcohol Abstinence Self-Efficacy Scale**

The Alcohol Abstinence Self-Efficacy Scale (AASE) measures an individual's self-efficacy in abstaining from alcohol (DiClemente et al., 1994). Although similar to the SCQ, the AASE focuses on clients' confidence in their ability to abstain from drinking across a range of 20 different situations derived from the eight high-risk categories listed above. The AASE consists of 20 items and can be used to assess both the temptation to drink and the confidence to abstain (see Figure 8-1). Clients rate their temptation to drink and their confidence that they would not drink in each situation on separate 5-point Likert scales that range from 1 (not at all likely) to 5 (extremely likely). Scores are calculated separately for temptation and self-efficacy (DiClemente et al., 1994). The items in this version are divided into several subcategories that measure four types of recurrence precipitants: negative affect, social situations, physical or other concerns, and craving and urges. A study conducted on 266 adults in treatment at an outpatient treatment program for alcohol use disorders over a 24-month period found strong indices of reliability and validity for this scale (DiClemente et al., 1994). This brief version also appears to be equally effective with men and women. It is easy to use, comprehensive, and a psychometrically sound measure of self-efficacy to abstain from drinking.
Readiness To Change

An instrument for assessing the importance of change has been developed (Sobell et al., 1996b), based on a four-question scale originally used with smokers (Richmond et al., 1993). The questions were modified to inquire about drinking, with responses in a specific range for each question. A composite motivation score is calculated with a possible range from 0 to 10, based on the sum of the responses. The four questions are

1. Would you like to reduce or quit drinking if you could do so easily? (No = 0, Yes = 1)
2. How seriously would you like to reduce or quit drinking altogether? (Not at all seriously = 0, Not very seriously = 1, Fairly seriously = 2, Very seriously = 3)
3. Do you intend to reduce or quit drinking in the next 2 weeks? (Definitely no = 0, Probably no = 1, Probably yes = 2, Definitely yes = 3)
4. What is the possibility that 12 months from now you will not have a problem with alcohol? (Definitely not = 0, Probably not = 1, Probably will = 2, Definitely will = 3)

As discussed throughout this TIP, readiness to change can be considered a prerequisite for responding to treatment. However, motivational states are not binary—with clients either motivated or not motivated. Rather, readiness exists along a continuum of steps or stages and can vary rapidly, sometimes from day to day. The stages-of-change model has inspired instruments for assessing readiness to change or a client's motivational change state. Depending on the level of readiness—or change stage—different motivational intervention strategies will be more or less effective (see Chapters 2 through 7).

Readiness Ruler

The Readiness Ruler, developed by Rollnick and used extensively in general medical settings, is a simple method for determining clients' readiness to change by asking where they are on a scale of 1 to 10 (see Figure 8-2). The lower numbers indicate less readiness, and the higher numbers indicate greater readiness for change. Depending on how ready to change clients think they are, the conversation can take different directions. For those who rate themselves as "not ready" (0 to 3), some clinicians suggest expressing concern, offering information, and providing support and followup. For those who are unsure (4 to 7), explore the positive and negative aspects of treatment. For clients who are ready for change (8 to 10), help plan action, identify resources, and convey hope (Bernstein et al., 1997a). As clients continue in treatment, you can use the ruler periodically to monitor how motivation changes as treatment progresses. Remember that clients can move both forward and backward. Also, helping clients move forward, even if they never reach a decisionmaking or action stage, is an acceptable outcome. Most clients cycle through the change stages several times, sometimes spiraling up and sometimes down, before they settle into treatment or stable recovery. One significant feature of the readiness to change scale is that clients assess their own readiness by marking the ruler or voicing a number. Another feature is that the clinician can pose the question, "What would it take to move from a 3 to a 5?" or can recognize movement along the continuum by asking, "Where have you come from last year to now?" Chapter 4 provides more information about fostering readiness.

In other similar studies (Sobell et al., 1993b; Sobell and Sobell, 1993, 1995b), clients responded on a scale of 0 to 100 to the following two questions:

1. At this moment, how important is it that you change your current drinking? (Not important at all = 0, About as important as most of the other things I would like to achieve now = 50, Most important thing in my life now = 100)
2. At this moment, how confident are you that you will change your current drinking? (I do not think I will achieve my goal = 0, I have a 50 percent chance of meeting my goal = 50, I think I will definitely achieve my goal = 100)

Both goal importance and confidence ratings have been associated with better treatment outcomes (Sobell et al., 1996b).

University of Rhode Island Change Assessment Scale

The University of Rhode Island Change Assessment Scale (URICA) was originally developed to measure a client's change stage in psychotherapy (McConnaughy et al., 1983) in terms of four stages of change: precontemplation, contemplation, action, and maintenance. The scale has 32 items, with eight items for each of the four stage-specific subscales (see Appendix B). Respondents rate items on a five-point Likert scale from 1 (strong disagreement) to 5 (strong agreement). Scores for each of the four stages are obtained. The instrument is
designed for a broad range of concerns and asks clients general questions about their "problem."

A 28-item version of the URICA, with seven items corresponding to each stage, has also been used with clients in alcoholism treatment (DiClemente et al., 1994). Subscale scores from this instrument can then be used to create profiles related to the stages of change or to create a single readiness score by adding together the contemplation, action, and maintenance mean scores and subtracting the precontemplation score. In various research studies, these scores have been related to treatment outcome. In Project MATCH, a multisite clinical trial of psychosocial treatments for alcohol problems that involved 1,726 clients, the readiness score predicted abstinence from drinking outcomes at a 3-year followup (Project MATCH Research Group, 1997a).

**Stages of Change Readiness and Treatment Eagerness Scale**

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) measures readiness to change, with items specifically focused on problem drinkers. Developed in 1987 by William R. Miller, the initial set of items was circulated for comment among colleagues in substance abuse treatment research. A 32-item version was then produced, using five-point scales ranging from five (strongly agree) to one (strongly disagree). The current 19-item version of SOCRATES, reproduced in Appendix B, was initially developed in 1991 and was used as a self-administered paper-and-pencil questionnaire in Project MATCH (Miller and Tonigan, 1996). The items on this short version do not measure the five stages of change constructs, but relate to three factors that have little overlap with each other: taking steps, recognition, and ambivalence.

Clinicians can use SOCRATES to provide clients with feedback about their scores as a starting point for discussion. Changes in scores when the scale is readministered could assess the impact of an intervention on problem recognition, ambivalence, and progress on making changes. Parallel forms have been developed to assess motivation to change substance use as well as the motivation of a significant other to help change a partner's substance-using patterns. The SOCRATES variables can also be helpful, in combination with other measures, for understanding the structure of motivation and readiness for change. Spanish translations are available.

**Readiness To Change Questionnaire**

The Readiness To Change Questionnaire (RCQ) was developed to help professionals who are not substance abuse treatment specialists assess the change stage of clients who drink excessively (Rollnick et al., 1992b). The 12 items, which were adapted from the URICA items, correlate closely with three change stages—precontemplation, contemplation, and action—and reflect typical attitudes of persons in each of those readiness levels. For example, a person not yet contemplating change would likely give a positive response to the statement, "Drinking less alcohol would be pointless for me," whereas a person already taking action would agree with the statement, "I have just recently changed my drinking habits." Another individual already contemplating change would be expected to agree with the item, "Sometimes I think I should cut down on my drinking." A five-point scale is used for rating responses, from strongly agree (5) to strongly disagree (1).

The RCQ, which can be self-administered, has been shown to have good psychometric properties with heavy drinkers in nontreatment settings. When the instrument was used as a screening tool with heavy drinkers in general hospitals, it accurately reflected patients' readiness to change and also predicted changes in respondents' alcohol consumption patterns at 8 weeks and 6 months following hospital discharge. That is, those who were least ready to change showed the least improvement in drinking patterns at followup, whereas those who were most ready to act did so (Heather et al., 1993). An additional test of the instrument found that men identified as heavy drinkers in general hospital wards and as being in early stages of change responded more favorably to brief motivational interviewing than to skills-based counseling with respect to reduced alcohol consumption. The inverse, however, was not found to be true. Men rated as ready to change did not respond any more favorably to skills-based counseling than to brief motivational interviewing. The study authors concluded that more research is necessary to ascertain what type of counseling is most suitable for persons identified as excessive drinkers in opportunistic settings who are also in a state of readiness to change (Heather et al., 1996a).

In repeated uses of the RCQ, Heather and colleagues have refined the scoring method for this instrument. The initial "quick method" simply sums the raw scores for each separate change-stage scale and uses the score that is farthest along the continuum of change stages as the most accurate reflection of the client's readiness to change. This method is appropriate if you need a quick way of determining readiness. A more accurate and refined method and a better predictor of change for research and clinical purposes is to omit any illogical and unreliable responses and add a preparation stage to the calculations. A revised version of the **Readiness To Change Questionnaire User's Manual** provides more specific information about calculating scores using this method.

The RCQ (Treatment Version) (RCQ [TV]) is a recent revision of the original RCQ (Heather et al., 1996b) that is a more appropriate alternative for determining the stage of change for persons who are seeking or already undergoing treatment for alcohol problems. This version, reproduced in Appendix B, responds to criticisms that the original RCQ was intended only for use with heavy or hazardous drinkers identified in opportunistic settings (Gavin et al., 1998), although it was being administered, inappropriately, to some alcohol-dependent persons already applying for treatment of a substance use disorder. The major problem was that drinkers identified in health care settings often chose to reduce consumption to safe limits instead of abstinence, which is the more typical decision of severely impaired persons in need of traditional treatment.

Although the developers of the revised instrument initially hoped to add questions that would identify persons in the five stages of change and to modify the questions to reflect goals of either reduced drinking or abstinence, only the latter aim was achieved with the revised instrument (Heather et al., 1996b). The RCQ (TV) has 30 items, with six questions corresponding to each change stage, which are rated on a five-point scale ranging from strongly agree to strongly disagree. Many of the questions and statements are adaptations of those in the original RCQ that now include abstinence as a goal. For example, "I have started to carry out a plan to cut down or quit drinking." Other new questions reflect the two additional change stages, "I've succeeded in stopping or cutting down drinking and I want to stay that way" (maintenance) or, "I have made a plan to stop or cut down drinking and I intend to put this plan into practice" (preparation).

The developers of this psychometrically sound instrument claim it is clinically useful for deciding what types of services are most appropriate for persons entering treatment. Those who are identified as ready to change can immediately be offered skills-based, action-oriented services, while those who are not yet in an action stage should be given further motivational interventions until they progress further along the readiness continuum. More research is necessary to strengthen one of the scales and to determine the instrument's ability to predict drinking outcomes accurately (Heather et al., 1996b).

**Decisional Balancing**

As discussed in Chapter 5, exercises and instruments that examine decisional balancing investigate the positive and negative aspects of a particular behavior. The general benefits of the behavior--and also of changing it--are weighed against the costs, allowing clients to appraise the impact of their behavior and make more informed choices regarding changing it. The scale reproduced in this section can be used to accentuate the costs of the client's substance use, lessen its perceived rewards, make the benefits of recovery more apparent, and identify possible obstacles to change.

The decisional balancing exercise was developed by Sobell and colleagues to help individuals identify benefits and costs of substance use as part of a cognitive appraisal process often associated with self-directed change (Sobell et al., 1996b). Such a purposeful comparison of the costs and benefits appears to facilitate the recognition and resolution of associated problems. Ask individuals who are interested in making a behavioral change to list benefits and costs of changing and not changing in parallel columns. Then ask them to carefully consider, "Are the costs worth it?" Figure 8-3 is an example of an exercise on the decision to change.

In another decisional balancing exercise, the Alcohol (and Illegal Drugs) Decisional Balance Scale, developed by DiClemente and reproduced in Appendix B, respondents are asked to indicate on a five-point scale how important each statement is in making a decision to change drinking or drug-using behavior.

**Alcohol and Drug Consequences Questionnaire**

The Alcohol and Drug Consequences Questionnaire (ADCQ) is a relatively new instrument for assessing the costs and benefits of changing a substance problem (Cunningham et al., 1997). It is reproduced in Appendix B. The 29 items included on the questionnaire were derived from information reported by clients participating in a brief cognitive-behavioral intervention for guided self-change at an outpatient substance abuse treatment facility. The items are divided into two categories: costs of change and benefits of change. Respondents are asked the importance of each item if they were to stop or cut down their use of substances (0 = not applicable, 1 = not important, 3 = moderately important, 4 = very important, 5 = extremely important). The score is determined by adding the cost items and the benefits items to obtain two separate scores that can be compared.

In initial tests of the instrument, respondents' anticipated costs and benefits of change were significantly related to the importance they attached to achieving treatment goals, and, for problem drinkers, to their drinking outcomes. Respondents whose scores were higher on the costs of change measures were more likely to have consumed more drinks in the year following treatment, whereas those who believed the benefits of change were more important than costs were likely to reduce drinking levels posttreatment (Cunningham et al., 1997).
Motivation for Using Substances

An underlying purpose of the instruments described in this section is to encourage clients to express their expectations about substance use by completing such statements as, "If I were to stop using substances, I would expect to feel..." Research suggests that expectancies play an important role in the progression from use to abuse (Brown, 1993; Connors and Maisto, 1988; Leigh, 1989a). Knowledge of clients' expectations regarding the effects of substances may help you understand the rationale for their substance-using behavior--clients who expect good things from substance use in most situations are likely to continue using at the same level until there is a change in perspective. Based on clients' expectations, find discrepancies between clients' behaviors and hopes and select strategies to help them address reasons for their substance use.

As with other measurement areas, less is known about motivations for using drugs than for using alcohol. The scales discussed in this section vary in length and have not all been tested on clinical samples. Leigh has reviewed and presented sample items and instructions for several questionnaires that purport to measure motivation (Leigh, 1989a).

Alcohol Expectancy Questionnaire

The Alcohol Expectancy Questionnaire is the most widely used of these instruments (Brown et al., 1987). It is reproduced in Appendix B. It contains 90 items and uses a dichotomous agree/disagree response format. The items are grouped into six categories of perceived benefits from alcohol:

1. Global positive changes
2. Social and physical pleasure
3. Sexual enhancement
4. Increased social assertion
5. Tension reduction/relaxation
6. Increased arousal and aggression

This scale measures only positive expectancies, not negative ones, and has been useful in showing that clients with continued positive expectancies at the end of treatment have poorer outcomes. It has been used with adults in both clinical and nonclinical populations (Sobell et al., 1994). A 120-item version that used the same format was developed for adolescents (Christiansen et al., 1982).

Alcohol Effects Questionnaire

The Alcohol Effects Questionnaire, reproduced in Appendix B, was constructed after researchers questioned whether the original Alcohol Expectancy Questionnaire measured the strength or intensity of alcohol-related expectancies (Collins et al., 1990). Subjects in a study were asked to rate the strength of their beliefs in addition to the agree/disagree responses in the standard Alcohol Expectancy Questionnaire. It was hoped that this study would clarify the distinction between two types of alcohol expectancies--the nature of an attitude toward a behavior and the strength of that attitude or confidence about behavior change. Subjects were asked to report how strongly they agreed or disagreed with a particular belief on a 10-point Likert scale where 1 = mildly believe and 10 = strongly believe. The results supported the idea that the strength of an individual's belief or disbelief in alcohol-related expectancies assessed by the Alcohol Expectancy Questionnaire is different from merely agreeing or disagreeing with these same expectancies.

Other Scales

The Effects of Drinking Alcohol scale has 20 items, each rated on a five-point scale that ranges from unlikely to very likely. The items, which reflect expected reactions to alcohol use, are grouped into five factors: nastiness, cognitive/physical impairment, disinhibition, gregariousness, and depressant effects (Leigh, 1989a).

The Alcohol Effects Scale is a 37-item, forced-choice adjective checklist that measures three factors: stimulation/perceived dominance, pleasurable disinhibition, and behavioral impairment (Southwick et al., 1981). This scale measures client expectations of how a moderate amount or excessive amount of alcohol would affect them.

The Alcohol Belief Scale was developed to assess clients' expectations regarding the usefulness of drinking different amounts of alcohol in different contexts (Connors and Maisto, 1988; Connors et al., 1987). The scale measures clients' beliefs regarding whether, for example, alcohol reduces discomfort in proportion to the amount
consumed ("The more I drink, the better I feel") (Connors et al., 1987). The greatest positive expectations are reported by those with the most severe drinking problems.

The Marijuana Effect Expectancy Questionnaire (MEEQ) and the Cocaine Effect Expectancy Questionnaire (CEEQ) are two related scales that assess motivation to use substances (Schafer and Brown, 1991). The MEEQ (70 items) and CEEQ (64 items) use a yes/no format with agree/disagree instructions similar to those of the AEQ. Subjects are asked to respond to the items according to their own beliefs and whether they have actually used the substance. Further research is needed; it appears, however, that expectancies differ across substance types in relation to the properties of the substance (e.g., expectation of arousal from alcohol and cocaine use but not from marijuana use).

**Goals and Values**

Your clients must value a treatment goal to progress toward it. In fact, unless clients value them, they are not goals from the clients’ perspectives. From a motivational standpoint, you should understand what your clients’ goals are and what they value in life. It is usually best to start where your clients are--with what is important from their own perspective.

Clinicians can assess goals and values through an open-ended interview, asking questions like, "What things are most important to you?" or, "How would you like your life to be different 5 years from now?" or "What would you like to have happen in treatment?" As an aid to this process, some clinicians use a sheet showing a number of bubbles that contain the names of issues that a client might wish to discuss and ask, "Which of these would you like to work on while you are here?" or "What might you like to work on first?" Some bubbles should be left empty, too, because clients may have goals other than those listed on the sheet. In developing a treatment plan, one can begin with all blank bubbles and fill in possible goals of treatment, then prioritize them. Miles Cox has developed and tested a clinical Motivational Structure Questionnaire for identifying goals and their associated degrees of commitment, outcome expectancy, and self-efficacy (Cox et al., 1993).

There are also more structured ways to assess what clients want and value. Clinicians can use the What I Want From Treatment Questionnaire, which lists a number of possible goals and aspects of treatment and asks new clients to rate the importance of incorporating each item into their own treatment (see Appendix B for a copy of this questionnaire). Clients can also be asked at the end of treatment the extent to which they received these same treatment elements. One study using this instrument found a positive relationship between favorable outcomes and clients reporting at discharge that they had received those treatment elements they said they wanted at intake (Brown and Miller, 1993). Receiving other treatment elements they did not want was unrelated to outcomes. In other words, clients improve to the extent they receive what they want from treatment.

Extensive literature exists on measuring values in general. For example, the Study of Values Questionnaire developed in 1960 has been widely used (Allport et al., 1960). In a classic volume on the subject, Rokeach introduced a method for ranking instrumental (means) and terminal (ends) values (Rokeach, 1973). His well-researched instrument, which is available in a published form, allows clients to prioritize their values by arranging small labels in hierarchical fashion (Rokeach, 1983). Another instrument has clients sort and prioritize cards dealing with a wide variety of values expressed in contemporary language (Miller and C'de Baca, 1994).
### Table 8-1: 20-Item Alcohol Abstinence Self-Efficacy Scale

#### Negative Effect
- When I am feeling angry inside
- When I sense everything is going wrong for me
- When I am feeling depressed
- When I feel like becoming angry because of frustration
- When I am very worried

#### Social/Positive
- When I see others drinking at a bar or at a party
- When I am excited or celebrating with others
- When I am on vacation and want to relax
- When people I used to drink with encourage me to drink
- When I am being offered a drink in a social situation

#### Physical and Other Concerns
- When I have a headache
- When I am tired
- When I am concerned about someone
- When I am experiencing some physical pain or injury
- When I dream about taking a drink

#### Craving and Urges
- When I am in agony because of stopping or withdrawing from alcohol use
- When I have the urge to try just one drink to see what happens
- When I am feeling a physical need or craving for alcohol
- When I want to test my will power over drinking
- When I experience an urge or impulse to take a drink that catches me unprepared

*Source: DiClemente et al., 1994.*
### Figure 8-3: Deciding To Change

<table>
<thead>
<tr>
<th>Changing</th>
<th>Not Changing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td>Increased control over my life</td>
<td>More relaxed</td>
</tr>
<tr>
<td>Support from family and friends</td>
<td>More fun at parties</td>
</tr>
<tr>
<td>Decreased job problems</td>
<td>Don’t have to think about my problems</td>
</tr>
<tr>
<td>Financial gain</td>
<td></td>
</tr>
<tr>
<td>Improved health</td>
<td></td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td><strong>Costs</strong></td>
</tr>
<tr>
<td>Increased stress/anxiety</td>
<td>Disapproval from friends and family</td>
</tr>
<tr>
<td>Feel more depressed</td>
<td>Money problems</td>
</tr>
<tr>
<td>Increased boredom</td>
<td>Could lose my job</td>
</tr>
<tr>
<td>Sleeping problems</td>
<td>Damage to close relationships</td>
</tr>
<tr>
<td></td>
<td>Increased health risks</td>
</tr>
</tbody>
</table>

*Source: Sobell et al., 1996b.*