

HARM REDUCTION AND MODERATION

AS AN ALTERNATIVE TO HEAVY DRINKING

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It is truly shocking that the issue of controlled drinking still evokes such violent debate. Most people simply don't know the facts regarding controlled drinking as a viable alternative for some problem drinkers. Popular press, driven by a strong 12-step coalition, has created an abstinence-only public mind set: Those with the disease of alcoholism (defined nebulously as "people with drinking problems") simply should not drink at all and that for professionals to advocate anything but abstinence and AA attendance is tantamount to malpractice. The purpose of this article is to set the record straight with regard to the controlled drinking debate.

The debate began in the early 1960s when the prominent the British physician, D.L. Davies (1962) published a paper documenting his observation that a percentage of patients in an abstinence based program had come to drink "innocuously." He advocated further research in this area. The paper sparked tremendous rage in the alcoholism field.

Davies findings were replicated by the Rand Corporation in the 1970s (Armor, Polich, Stambul, 1978). The authors followed the patients of 45 alcohol treatment centers for 18 months. They discovered that about 70% had showed improvement, though only a small percentage were completely abstinent. Many had reduced their alcohol consumption to non-problematic levels. The authors stated, "...some alcoholics can return to moderate drinking with no greater chance of relapse than if they abstained." (p 294). At three-year follow (Polich, Armor & Braiker, 1981) it was found that 18% of a random cohort of the patients were drinking without problems. As was the case with Davie's research, hostile commentary ensued from disease model extremists.

Many researchers evaluated controlled drinking in the 1970s, but it was Mark and Linda Sobell who received international attention from their evaluation of chronic male alcoholics (1973, 1976, 1978). The

patients were 70 alcohol dependent individuals from Patton State Hospital. Patients were randomly assigned to abstinence or controlled drinking treatment. The controlled drinking patients received functional analysis education, problem solving training, drinking moderation skills, aversive counter-conditioning, exposure to videotapes of their own behavior while intoxicated and general education about drinking and effects of alcohol. Control subjects received AA meetings, group therapy, chemotherapy, physiotherapy and industrial training (standard inpatient fare). All patients were followed for two years. Quantity of alcohol consumed and a number of psychosocial variables were evaluated. Results suggested that moderation might be a preferable treatment goal for some alcoholics. At one year, controlled drinking clients were found to be functioning well for a mean of 71% of all days, as opposed to abstinence group who were functioning well on only 35% of days. At two-year follow-up, the figures were 85% and 42% respectively. As G. Alan Marlatt (who wrote a very thorough article in Behavior Therapy (Vol24, 4, Fall 93) titled: Harm Reduction and Alcohol Problems: Moving Beyond The Controlled Drinking Controversy) points out, one limitation of the study was that Linda Sobell conducted all of the patient interviews, and data collection was therefore not "blind." Fortunately, standardized, objective questionnaires were used, and all interviews were tape recorded and open to independent evaluation. An independent evaluation of the data was conducted by Glen Caddy, who reported that the controlled drinking subjects continued to be functioning better than the abstinence subjects.

Then in 1982 the findings of Mark and Linda Sobell were evaluated by Mary Pendry, Irving Maltzman, and Joyn West (Pendry, Maltzman, & West, 1982). In their study, published in Science, the authors flatly accused the Sobells of research fraud and extremely poor judgement. Mary Pendry had personally interviewed as many of the Sobell subjects as possible as to their drinking patterns since the Patton State study. They concluded that the Sobells were frauds and that the controlled drinking training had actually done harm. Most shocking was their discovery that only one of the controlled drinking patients was doing well, four had died and one was missing. The authors couched their findings in tabloid-melodramatic terms.

The greatest flaw in the Science publication was the fact that nothing was said of the control subjects (those who received abstinence treatment). The authors defended the one sided report by stating that the comparison of the two groups was not the important issue: "We are addressing the question of whether controlled drinking is itself a desirable treatment goal, not the question of whether patients directed toward that goal fared better or worse than a control group that all agree fared badly (pp. 172-173). It is simply impossible to evaluate the success of a treatment without comparing it to a control. Clearly the authors knew that revealing the data of abstinence subjects would seriously reduce the impact of their findings: Though 4 of the control subs had died, 6 of the abstinence group had died.

Marlatt, in his excellent summary of the controlled drinking dispute, pointed out that the other flaw was that Pendry and her colleagues based their "findings" on retrospective self-reports of the past 5 - 10 years. Pendry is a strong advocate for 12-step approaches and the possibility of experimenter bias is likely. There was also no objective data obtained, as was the case with the Sobells. Most dangerous was the fact that Pendry and her colleague were attempting to posit that the patients died as a function of taking part in the controlled drinking study, that the Sobells were in fact responsible for their deaths. Marlatt reports "Pendry and her colleagues attempted to convince readers that the long-term negative results they reported were the direct effect of a single controlled drinking program conducted a decade earlier. The problem with drawing such a causal inference over a protracted period is that the literature on the effectiveness of alcoholism treatment methods contains very few studies documenting the lasting effectiveness of any one treatment intervention over periods longer than two or three years, including programs geared toward an abstinence goal (p.473).

Most disturbing is that Pendry et.al. took their study on the road. Numerous newspaper interviews, including one with The New York Times, as well as an extremely pejorative segment on 60 minutes, launched the biased findings of their crusade into the public eye.

In response, the Addiction Research Foundation in Toronto appointed a noteworthy panel of independent investigators (The Dickens Committee, Dickens et.al., 1982) to review the Sobells findings. Their

report vindicated the Sobells on all counts: "In response to the allegations (by Pendry et.al.) the Committee examined both the published authored by the Sobells as well as a great quantity of data which formed the basis of these published reports. After isolating each of the separate allegations, the Committee examined all of the available evidence. The committees conclusion is clear and unequivocal: the committee finds there to be no reasonable cause to doubt the scientific or personal integrity of either Dr. Mark Sobell or Dr. Linda Sobell" (p.109). A separate panel conducted at the request of the ADAMHA corroborated the findings of this panel (The Trachtenberg Report; 1984).

Sadly, though completely exonerated, the schlock journalism associated with the Pendry et.al. study has stuck in many people's minds. Most people, even those in the addiction counseling field, do not keep up with current research and rather rely on popular press to keep them abreast. Most people who have heard of the Sobells believe them to be fraudulent criminals. Maltzman still brazenly publishes reports claiming that the Sobells are crooked.

Published research since the Sobells supports the following: Controlled drinking is a common outcome from abstinence based treatment programs; controlled drinking training can be efficacious with non-physically dependent problem drinkers. In response to research supporting the former, Bill Miller and his colleagues (1992) suggest that allowing moderation goals (i.e. having a low threshold with regard to the goals of those entering treatment) provided a pathway to abstinence for individuals who would not otherwise have entered treatment. p487. Furthermore, research on goals establishment suggests that using patient goals (abstinence versus moderation), increases compliance, reduces dropout and actually is associated with the eventual outcome.

The Institute of Medicine (1990) pointed out that we are "out of touch" with approximately 80% of alcoholics. These folks have legitimate drinking problems and are not in contact with addiction treatment services. Advocates of the 12-step model contend that these people are simply "in denial" and need to "hit bottom" before they will align themselves with treatment. Marlatt contends (1993) that it is more likely that many of these people simply do not wish to enter

treatment with dichotomous requirements and would be more compliant if offered alternatives.

One of the most fruitful areas of research has been in the area of controlled drinking as an outcome for non-physically dependent problem drinkers. The problem drinker does not experience symptoms of alcohol dependence and has a shorter drinking history. Often referred to as "early stage problem drinkers," this group represents the vast majority of people with alcohol problems. Heather et al (1987) Skutle and Berg (1987) Sanchez-Craig and Marlatt et al, (1993) and others have found that moderation training is an effective treatment approach for this group. Success has been found to be maintained at one and two year follow-ups.

Sanchez-Craig (1984) suggests that individuals most likely to succeed with a moderation goal have the following characteristics:

1. The belief that moderation is a valuable and attainable goal.
2. The belief that pursuing the goal of moderation will not threaten important relationships or the security of a job.
3. A social network supportive of the goal of moderation
4. Willingness to commit time and effort to the achievement of the goal.

The following are also used as criteria:

1. Individuals should be in good physical and mental health. There should be no evidence of a medical condition for which any drinking is contraindicated. Moderation is not deemed appropriate for individuals in the throes of significant emotional turmoil.
2. Individuals should not be cognitively impaired.
3. Individuals should be socially stable and possess adequate social supports.
4. Individuals tend to do best with a moderation goal if alcohol use

has been problematic for less than 5 years.

5. Individuals do best if they score less than 14 on the Alcohol Dependence Scale (ADS)

6. Research only supports treatment with a moderation goal if excessive drinking is the main presenting problem. Polysubstance abusers don't fare as well.

Despite the research supporting moderation training for problem drinkers, many would consider anything short of total abstinence as a goal for a heavy drinker to be a failure "They are still drinking, which is unhealthy. Back to the drawing board!" I would argue that for a heavy drinker to significantly reduce the amount of alcohol consumed is a tremendous success. It would certainly be nice if everyone engaged only in behaviors that were completely healthy. But in the real world, very few behaviors meet this criterion. Furthermore, goodness and badness occur along a vast continuum and are subject to individual interpretation. The harm reduction model upholds that any movement toward improved well being and reduced harm is positive in and of itself. If heavy drinkers can cut down on their alcohol consumption to any degree, this is positive and should be praised as an accomplishment.

Should professionals teach moderation training?

Problem drinkers vary considerably in terms of level of severity, configuration of antecedents which trigger heavy drinking, types of consequences which are of concern (e.g. legal, health, interpersonal) and individual goals and standards. Ideally, treatment for alcohol problems should begin with a thorough assessment of the aforementioned variables so that a recommendation can be made as to the most potentially effective and least invasive approach which is most consistent with existing values. Some individuals can benefit from brief motivationally oriented contacts or involvement in self-help groups like Rational Recovery or Alcoholics Anonymous. Others require more intensive treatment, such as weekly individual therapy, partial hospitalization or inpatient treatment. Many individuals with drinking problems desire to learn how to moderate their drinking as opposed to abstaining. As stated, research strongly supports the

efficacy of moderation training for non-physically dependent problem drinkers. Furthermore, many individuals who pursue moderation ultimately opt for an alcohol-free lifestyle. Moderation training, therefore, is appropriate and should be included in the spectrum of addiction treatments.

However, Harm Reduction philosophy and empirically driven wisdom buck horns when people desire a treatment goal which is not commensurate to the level of problem severity. An example would be a drinker who has consumed a fifth of Gin per day for 15 years who wishes to "just cut down." We can all agree that it is good news if a guy who drinks a fifth of Gin a day cuts back to four beers, but is it appropriate for a professional to teach a guy who drinks a fifth of Gin to cut back to four beers. If this individual claimed that he would not voluntarily take part in any treatment unless moderation was the outcome goal, then, from a harm reduction perspective, the answer would be yes. Abstinence is certainly indicated, but moderation is a step in the right direction. What then can be said regarding the accountability of the counselor if this individual, during the duration of treatment, gets drunk, drives through a school yard and injures several children. What are the legal consequences when it is brought to the attention of the court that the counselor was training a man who drank massive quantities of alcohol how to control his drinking. Chances are this counselor would be held accountable to some degree.

I believe that health care professionals should be held accountable for their actions and that clinical interventions should be driven by research. I also uphold the Harm Reduction philosophy. Sometimes the two don't mix. Helping people move toward their desired goal is not necessarily what the research has supported as the most potentially successful goal. Does this mean that people should be denied treatment if they don't acquiesce to the goal which is most commensurate to research findings? I believe that health care professionals must advocate the complete elimination of harm...and hope for the best. The best solution in the case of the strong willed gin drinker would be to uphold the abstinence goal as the ideal way for him to reduce risk and improve health, but also accept that any decrease in drinking or alcohol-associated risk behavior (like driving while intoxicated) would be very positive. Afford this individual

treatment which entails the development of skills to reduce drinking. How much he intends to implement the skills into his lifestyle is of course his decision. If he implements them at all, it is good and should be praised as a monumental accomplishment.

So let us assume that this individual, who had previously been in the throes of a significant drinking problem also drove frequently with a BAL well above the legal limit. After being exposed to the most empirically driven treatment with an abstinence goal, he comes to reduce his daily intake to a moderate level with the exception of week-end binges at a local bar, from which he uses public transportation to travel home. Let's imagine that this pattern of drinking becomes stable. Can we deem this a success? Some might adamantly say "No," as this is an individual who has had many years of heavy drinking and has undoubtedly succumbed to myriad health sequelae who is still drinking alcohol! It is completely true that he continues to engage in harmful behavior and that he would benefit considerably if he quit completely. Few could realistically argue that this man should take another sip. However, he chooses to do so, despite top notch treatment and advice. It must be accepted that this man values a drinking lifestyle greatly and that in his mind the consequences of giving up entirely, outweigh the consequences of continuing drink. It must also be accepted that without treatment he may have continued drinking at the previous level of severity, if not higher. Via exposure to treatment, this individual has come to reduce very heavy daily drinking to moderate daily drinking coupled with week-end binges. The associated harm of his behavior has been reduced substantially: He has slowed down the progression of harm to liver, pancreas and other vital organs; he has enhanced other areas of his life due to the fact that he is not drunk all day long; he has reduced likelihood of incarceration and injuring or killing himself or others by driving drunk. This individual should be encouraged to continue considering the benefits of reducing further or eliminating altogether, but if he says, "Thank you no, I'm finished. I feel great now. I've tried quitting entirely and it just doesn't work with my lifestyle, I always rebound full throttle. I can maintain my current level of drinking which I don't wish to give up" rather than viewing this person as "in denial" or "an addictive personality" it must simply be accepted that he made significant progress and improved his life, and with regard to the problem at hand, perhaps as much as he ever will.

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