CHAPTER 1

Conceptual Foundations: Defining Alcohol Problems

TRUTH OR FICTION QUIZ

After reading this chapter, you will be able to answer true or false to the following statements:

1. **Either you have an alcohol problem or you don't.** True or False?
2. **Most people who have problems with alcohol need treatment to overcome them.** True or False?
3. **Alcohol problems are mostly inherited.** True or False?
4. **Lifelong abstinence is the only way to recover from alcohol problems.** True or False?

Answers on p. 21.

Alcohol Problems: What Are They, Who's Got Them, Who Hasn't, Who Might?

Alcohol is the most widely used drug in the United States after caffeine (we do love our Starbuck's). In fact, according to statistics compiled by the Centers for Disease Control (CDC), in 2001 nearly 63% of Americans over the age of 18 reported being a current drinker of alcohol. Compare this with about 23% of the adult population who smoke cigarettes and far fewer people who use illegal drugs. Yet alcohol is a drug about which society is extremely ambivalent, as the quotations at the beginning of this chapter surely demonstrate. While only about 7% of males and slightly less than 3% of females over the age of 18 suffer from "diagnosable" problems related to alcohol use, in 2001 nearly a third of all Americans surveyed reported that they drank five or more drinks (the level at which alcohol consumption begins to be associated reliably with negative consequences) on one occasion at least once during the past year. More startling is that 15% reported drinking at this level at least once a month, according to the CDC.

What do all these statistics and quotations mean? What they mean is that alcohol use is both a pleasant and important aspect of life for many Americans, and

a source of difficulties for many others. The difficulties experienced by people who use alcohol include alcohol-related health problems, lost productivity at work, crime, motor vehicle crashes and other accidents. In 2000, the National Institute on Alcohol Abuse and Alcoholism estimated that the total monetary cost of these alcohol-related negative consequences would be more than $184 billion. That's "billion" with a "b"! That's nearly as much as the gross national product of Poland, and more than the gross national products of Indonesia and Thailand.

With alcohol consumption clearly bringing immense costs, it's important that we, as a society, begin to develop systematic ways of both preventing costs from occurring and reducing costs to individuals for whom they have already occurred. However, alcohol can also bring immense pleasure, and there are documented health benefits associated with moderate alcohol use. These benefits are such that the U.S. Department of Agriculture now includes a small amount of alcohol consumption in its daily guidelines for a healthy diet.

> "The sway of alcohol over mankind is unquestionably due to its power to stimulate the mystical faculties of human nature…. sobriety diminishes, discriminates and says 'no' drunkenness expands, unites, and says 'yes.'"
>
> —WILLIAM JAMES

The dilemma we face is in distinguishing alcohol use that is likely to cause harm, or already has done so, from alcohol use that is likely to bring with it benefits to subjective well being and health. To do so, we need to look beyond how much a particular individual drinks (quantity) to a variety of factors that are often overlooked by non-professionals in ascribing the label of "problem" to a person's drinking. These factors include, but are not limited to age, height, weight, ethnicity, gender, occupation (yes, your work does affect the likelihood that you will use alcohol in a problematic way), family environment, and other psychological and behavioral factors. As we consider various definitions we will see how these factors come into play, and how important it is to consider them in understanding and reacting to a particular person's drinking.

Defining Alcohol Problems

Before we can examine how we define alcohol problems, a few words about alcohol itself are in order.

Alcohol is a psychoactive drug. As such, it is a substance that many (in fact, most) drinkers use without problems. What makes people drink in the first place? As with any psychoactive substance, alcohol use is driven primarily by a desire to achieve a particular effect. The exact nature of that effect may vary from person to person, but desired changes in emotion, thought, and behavior are what motivates alcohol use for every drinker.

So, what are these effects? Well, it's important to recognize that alcohol does not affect all individuals in the same way, even at a biochemical level. Thus, many people of East Asian heritage (perhaps as many as one-third) respond to even small amounts of alcohol with an extremely unpleasant flushing reaction that makes alcohol consumption for these people an unpleasant experience. For most people, however, alcohol has a well-known pharmacological effect. Initially the effect is one of stimulation (seemingly contrary to alcohol's classification as a central nervous system depressant drug). However, as the drinker continues to consume alcohol and the percentage of alcohol in the blood and brain increases, alcohol's effects clearly become depressant. Motor and cognitive functioning begins to be altered first, and eventually, at high enough blood alcohol concentrations, respiratory arrest and death may occur.

Many of us have seen individuals who were intoxicated on alcohol. We've seen people who were unsteady on their feet, slurred their speech, had bloodshot eyes and flushed skin, were overly boisterous, or, to the contrary, fell asleep in the midst of a crowd of party-goers. We also may have seen drinkers who became hostile, depressed, happy. In addition to producing many of these effects, alcohol also affects reaction time and ability to rapidly process peripheral information. This is what makes driving a car under the influence of alcohol so risky. It's not that the drinker can't operate the car and keep it on the road adequately. It's that intoxicated drivers can't react quickly or effectively to sudden or unexpected changes (e.g., a car pulling out of a side street or a pedestrian walking in the road rather than on the sidewalk) and are more likely to crash as a result.

In problem drinkers, particularly those whose drinking is chronic and heavy and who have developed a high tolerance for alcohol's effects, many of these common signs of intoxication may not appear at all. One of us, for example, evaluated a client who, after more than a decade of heavy daily drinking, needed to maintain his blood alcohol concentration at .25% (the percentage of blood content that is alcohol, also often written as 250mg/deciliter) in order to forestall withdrawal symptoms. During the years prior to the evaluation, this client ran a business, was well liked by his customers and never had so much as a DUI arrest. He never appeared intoxicated to people around him who were unaware of his drinking, although he did always have thermos of vodka and orange juice handy in case his blood alcohol concentration dropped below comfortable levels. This client needed to drink simply in order to feel "normal" and to function. The behavioral signs of intoxication were largely invalid for him—he behaved "normally" when drunk!

Alcohol as a drug is somewhat different from other substances we think of as psychoactive drugs (e.g., marijuana, heroin, cocaine, methamphetamines). Alcohol is a very weak drug compared to other so-called recreational drugs. Effective doses of alcohol are measured in grams, while effective doses of other drugs are measured in milligrams. Nonetheless, alcohol is highly effective in altering mood and behavior largely because it readily crosses the blood-brain barrier. In fact, because it is soluble in water, alcohol diffuses throughout all bodily tissues.

While the exact mechanism through which alcohol exerts its psychoactive effects is not fully understood, it is clear that alcohol works through affecting neurochemistry in ways similar to other depressant or sedative drugs that alleviate anxiety. This can lead to the phenomenon of "cross tolerance" where individuals may find that they become more tolerant to the effects of alcohol when they are in the practice of using other sedative/hypnotic drugs, such as Valium or Xanax (though not at the same time that they are under the influence of alcohol).

"Drunkenness is nothing but voluntary madness."
—SENECA

As with other psychoactive drugs, pharmacology isn't the whole story of the drug's effects. Both psychological and environmental factors contribute to the effect alcohol has on a particular individual in a particular instance. Norman Zimberg, a Harvard psychiatrist, identified these three factors: drug (the pharmacological properties of a drug), set (the psychological and physiological factors unique to the particular individual), and setting (the context in which the substance is used) as being the multiple determinants of a drug's effects, especially at lower doses. All of these factors also come into play in the development of problems related to alcohol. The fact that alcohol effects are multi-factorial, rather than simply due to the pharmacology of alcohol itself, makes the whole issue of defining and identifying alcohol problems highly complicated.

Despite the complexity of alcohol problems, several proposed definitions are worth examining. These definitions vary in the extent to which they involve theoretical views of the nature of drinking problems (i.e., views that include thinking and concepts that grow out of popular and uncontrolled clinical studies of people with alcohol problems), but interestingly none focuses on alcohol use as a primary feature of alcohol problems. There are two types of definitions we will consider: Drinking Definitions and Diagnosis Definitions. Drinking Definitions describe aspects of drinking itself, while Diagnosis Definitions describe types of problems that arise from drinking. The Drinking Definitions we will discuss are: "harmful" drinking, "hazardous" drinking, "moderate" (or "controlled") drinking, and "binge" drinking. The Diagnosis Definitions we will review are the American Society of Addiction Medicine/American Medical Association definition of "alcoholism," and the American Psychiatric Association definitions of "Alcohol Abuse" and "Alcohol Dependence."

The various definitions of these terms serve to highlight controversies within the field that have often stood in the way of understanding drinking problems and developing effective ways of helping people overcome them. In fact, the same terms are often defined differently in different countries, which underscores the variability of both our views of drinking problems and the ways in which people are affected by alcohol consumption.

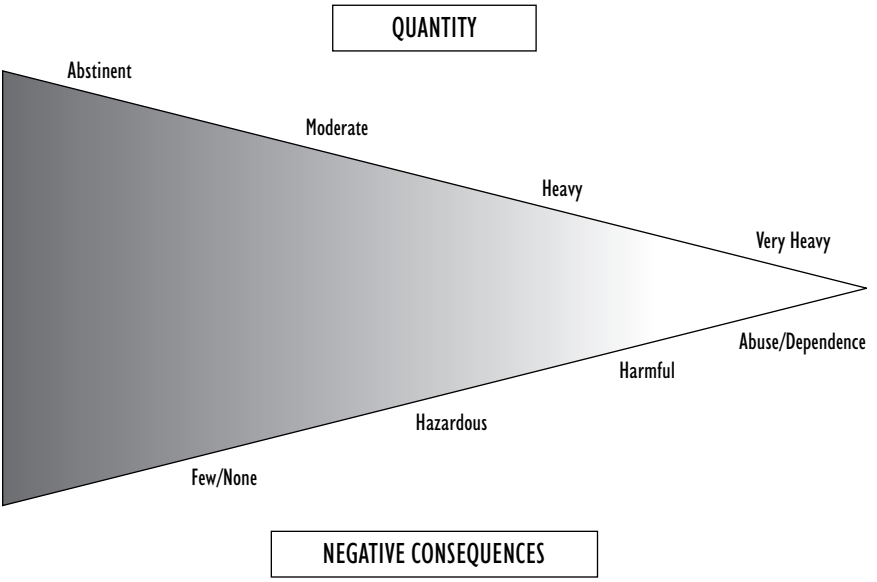

Figure 1.1: Continuum of alcohol problems.

Source: Adapted from the Institute of Medicine (1990).

Though we use what seem to be categorical terms to describe alcohol problems, it is important to recognize that these problems actually lie along a continuum, with no clear demarcation between the levels and types of problems. In 1990, the Institute of Medicine of the National Academy of Sciences issued a report that was probably the first to suggest this notion of a continuum in talking about alcohol problems. Figure 1.1 shows how the Institute of Medicine conceptualized alcohol problems.

The triangle represents the population of the United States. The top leg of the triangle represents the amounts that people in the United States drink. Surprisingly, about one third of Americans don't drink at all; most of these non-drinkers are women. The bottom leg of the triangle represents the degree of negative consequences associated with various amounts of drinking on the top leg of the triangle. The labels on each leg roughly approximate the corresponding terms that are defined below. People move back and forth along the continuum as their drinking and associated consequences change. This is an important idea that will be further considered later in the book.

Drinking Definitions

Hazardous drinking is another term for heavy drinking. Heavy drinking is defined in terms of number of drinks per week and is in contrast to moderate or controlled drinking. While specific drinking amounts have varied from country to country, and research study to research study, in recent years (due largely

to excellent work by Martha Sanchez-Craig and her colleagues at the Addiction Research Foundation in Toronto, Canada) a consensus appears to have formed that consumption of more than 14 drinks per week, or more than 4 drinks at a sitting, for men and more than 9 drinks per week, or more than 3 drinks at a sitting, for women constitutes hazardous drinking. It is important to realize that these are "average" or "aggregate" figures that are based on a mythical "average" person. Individuals of different heights and weights, experience with alcohol, with or without medical or other psychological problems will be affected differently by consuming these amounts. Nonetheless, on the average, drinking more than these amounts greatly increases the risk that a person will be harmed.

Harmful drinking is drinking that has actually caused harm, where the harm can clearly be attributed to the alcohol. However, there are some qualifications to this definition. One is that alcohol consumption has been persistent over at least a month or has occurred repeatedly over the course of a year. The other is that the person is not alcohol dependent (see definition, on p.12). This means that a person who is experiencing harmful drinking probably lies somewhere between the person who is alcohol dependent, or alcoholic, and the person who is a moderate drinker.

Moderate (or controlled) drinking is drinking that falls below the quantities and frequencies that define hazardous drinking. Thus, a moderate drinker consumes (if a man) no more than 14 drinks per week, and no more than 4 drinks at a sitting, or (if a woman) no more than 9 drinks per week and no more than 3 drinks at a sitting. Often the term "controlled" drinking is used to refer to a person who has suffered from alcohol dependence or alcoholism who has reduced their drinking to moderate levels.

This definition, as well as the two previous ones, raises the question of what is a "drink"? As with other definitions, this one also varies from country to country. For example, in Japan a "standard" drink contains 28 grams of alcohol, while in the United Kingdom a "standard" drink contains 8 grams.

In the United States, however, there is a more or less generally accepted definition of what is called a "standard" drink that states that a 12-ounce can of beer, a 5-ounce glass of table wine, or 1.5-ounces of 80 proof liquor are all "standard" drinks. That is, they all contain about the same amount of alcohol. When using the term "drink" throughout the rest of this book, I will adopt this definition. So when I speak of a person as being a "moderate" beer drinker, that means a man consumes no more than 14 12-ounce beers per week and a woman consumes no more than 9 12-ounce beers per week.

Our final Drinking Definition is *binge drinking*. As with the previous definitions, this one has numerous forms and is quite controversial. The definition of binge drinking often depends on who is using the definition and in reference to whom. Thus, a widely used definition of binge drinking has grown out of

studies of college students and other drinkers who are not alcoholics or alcohol dependent, but whose drinking appears to correspond to the definition of hazardous drinking outlined above. This definition defines a "binge" as consumption of 5 or more drinks on one occasion by a man or 4 or more drinks on one occasion by a woman. Again, the significance of these quantities varies from individual to individual. Thus, consumption of 5 standard drinks by a massive offensive lineman for a professional football team has a different implication for harm than does the consumption of the same 5 drinks by a professional jockey!

Clinically, when speaking about people who have a diagnosable alcohol problem, the term "binge" takes on another meaning. In this context, binge drinking is used to refer to a pattern of drinking in which a person drinks heavily for days or weeks at a time, but then stops drinking, again often for days or weeks at a time. This alternating pattern of drinking and abstinence is often called a binge-drinking pattern. Here, the quantities consumed usually exceed the 5 and 4 drinks referred to in the aforementioned definition of binge, and the person often remains almost continuously intoxicated during the binge-drinking period.

Notably, with the exception of harmful drinking, none of these definitions implies that drinking is or is not harmful to a particular person. The dividing line between harmful and hazardous drinking, between moderate and immoderate drinking, is a fine one—actually one drink more than the levels considered moderate. Consequently, a great deal of confusion exists when applying these definitions to individuals because the definitions fail to take individual differences into account. As we shall see, similar problems plague the Diagnosis Definitions.

Diagnosis Definitions

What is an "alcoholic"? How do I know if a relative or a friend is an "alcoholic"? As with everything else in this field, herein lies the controversy! Most of us use the term "alcoholic" to describe someone whose drinking has created problems for themselves or those around them. Yet, it is clear that drinking problems lie along a continuum of severity and impact on both the person and those around the person. It is important to ask questions like: "Is getting a single DWI citation indicative of 'alcoholism'?" "Is getting drunk at your daughter's wedding indicative of 'alcoholism'?"

As you consider the Diagnosis Definitions below, continue to ask yourself those same sorts of questions. In particular, ask those questions when thinking about your own drinking and that of your loved ones.

Most of us have heard of Alcoholics Anonymous (AA), the largest and most widespread self-help support group for people with alcohol problems. There are a number of others that will be considered in a subsequent chapter. We've also seen portrayals of alcoholics in films, such as "28 Days." People in AA call themselves "alcoholics." But what is the AA definition of "alcoholic"? Isn't it the same

as the more formal, medical definitions we will discuss shortly? Interestingly, the answer, despite the beliefs of many to the contrary, is "no." The AA definitions of "alcoholic" and "alcoholism" are not the same as the medical definitions. In fact, the so-called "Big Book" of Alcoholics Anonymous fails to provide a consistent definition of "alcoholic" at all. Rather, the problem drinker, according to the Big Book, takes on this designation by reading the book and identifying with the people whose stories appear therein. For AA, you're an "alcoholic" if you call yourself an "alcoholic." The "stretchiness" of this most familiar definition of problem drinking has contributed to the confusion. So much so that two prominent medical societies—the American Society of Addiction Medicine (ASAM) and the American Psychiatric Association (APA)—have attempted to reduce it by promulgating two quite different Diagnosis Definitions of alcohol problems.

"Wine is bottled poetry."
—ROBERT LOUIS STEVENSON

ASAM Definition of Alcoholism

ASAM put forward its definition of alcoholism in the early 1990s. ASAM defines alcoholism as:

> *a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most often denial.*

This is the prototypical statement of the notion of alcoholism as a "disease," a view that has itself produced much confusion and debate, particularly when it comes to deciding how to help people resolve alcohol problems. Interestingly, despite popular views to the contrary, this is not the view of alcoholism that is contained in the central writings of AA. Bill Wilson, one of the co-founders of AA, was clearly hesitant to call alcoholism a "disease" and uses that term only once or twice in the Big Book. The notion of alcoholism as a "disease" probably stems most directly from the work of researcher E.M. Jellinek in the 1950s, although even Jellinek acknowledged that there were some types of alcohol-related problems that were not diseases, nor did they fit the definition put forward in subsequent years by ASAM.

There are many problems with this widely accepted definition, problems that become manifest when one tries to apply it to a particular case. These problems revolve around the many qualifications in the definition, and the global nature of the terms of the definition that allow it to be applied to almost any alcohol-related problems. For example, the qualification "continuous or periodic" has no specific definition itself. Does periodic mean "once or twice" or more? Likewise, terms such as *denial*, which the ASAM definition's framers go to great lengths to explain in subsequent clarifications that are much longer than the definition

itself, have been shown to be problematic by researchers. Thus, while the ASAM definition suggests that denial is characteristic of the "disease of alcoholism," researchers have shown that, in fact, denial is an interpersonal process that seems to occur only when a drinker is confronted by another person telling the drinker that his or her drinking is a problem and should be changed. When the drinker is approached in a less label-focused, confrontational manner, denial is rare (more on this and other research in later chapters).

It is also unclear what is meant by terms such as *impaired control*. While a philosophical discussion of control and how it might be impaired by a disease like alcoholism is beyond the scope of this chapter, it is important to recognize that this concept is not as simple as it seems at first blush. So, for example, it has often been said that "alcoholics" are incompetent to decide on drinking reductions as opposed to abstinence. Yet, it is clear that many, many people who might be called alcoholics make the decision to enter treatment and/or to reduce or stop drinking while in the midst of a heavy drinking episode or its aftermath. At what point does control then become impaired?

Despite these problems, the ASAM definition of alcoholism is consistent with other Diagnosis Definitions in avoiding specific reference to the quantity and frequency of drinking. It also focuses largely on the consequences of drinking rather than the behavior of drinking itself.

The next set of Diagnosis Definitions was put forward by the American Psychiatric Association (APA) in its *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revision* (*DSM-IV-TR*) and also de-emphasizes drinking in favor of the consequences associated with drinking. The *DSM-IV* defines two types of alcohol problems under the heading of Psychoactive Substance Use Disorders: Alcohol Abuse and Alcohol Dependence. As these are the standard diagnostic definitions in the United States, we'll discuss them at some length. Before we do, however, a short digression to consider the use of the word "abuse" is in order.

Abusing "Abuse"

We've all heard the terms "substance abuse" or "alcohol abuse" or "drug abuse." These terms have become so broad as to be essentially meaningless in accurately capturing the phenomena we are interested in. These terms have often been used synonymously with "addiction." The confusion surrounding the term "alcohol abuse" has become so great that one of the most prestigious professional journals in the field, the *Journal of Studies on Alcohol*, has found it necessary to disseminate a specific editorial policy for what the term "alcohol abuse" will mean in its journal, and how the term must be used. (Because of the confusions noted previously, the journal has also disseminated a similar policy for the use of the term "binge." They use it only in the sense of prolonged heavy drinking and not to mean 5 or more drinks in a row.) In order to maintain clarity, we will do the

same here. When we use the term "alcohol abuse," we will use it only in the Diagnostic Definition sense, which is to indicate that a person meets the criteria to be diagnosed with the *DSM* disorder of Alcohol Abuse. When referring to alcohol use that is problematic but does not result in a diagnosable condition (i.e., Alcohol Abuse or Alcohol Dependence) we will use the terms "misuse" or "hazardous drinking." Let's now turn to a more complete discussion of the Diagnostic Definitions.

How the DSM Works

The *DSM-IV-TR* places all problems related to use of alcohol and other drugs into the larger class of Substance-Related Disorders. Under that heading, the framers of the *DSM-IV-TR* further define two classes of Alcohol-Related Disorders: Alcohol Use Disorders (Alcohol Abuse and Alcohol Dependence) and what they term Alcohol-Induced Disorders. Alcohol Intoxication, Withdrawal, Intoxication Delirium, and Withdrawal Delirium are the most prominent among these. However, nine other disorders that cover the full range of psychological symptoms might also be produced by alcohol. The latter are disorders that are directly related to the toxic effects of excessive alcohol consumption, either on a single occasion or over time.

We are most concerned here with the Alcohol Use Disorders, those that reflect consequences of alcohol use that accumulate over a long period of time but are not necessarily directly caused by the pharmacological toxicity of alcohol.

The *DSM-IV-TR*, like several of its predecessors, uses what some have called a "cookbook" or "Chinese menu" approach to diagnosis. In order to receive a particular diagnosis, a client must meet certain global criteria—the most prominent of which is "clinically significant impairment or distress" resulting from a "maladaptive pattern of substance use." (Global criteria will be discussed in more detail later.) A client must also present one or more of a series of more specific criteria. Not every client who receives a particular diagnosis will necessarily meet the same criteria for the diagnosis as another client. This means that two people who receive a diagnosis of Alcohol Dependence could, conceivably, not meet any of the same criteria for that diagnosis. This allows for (or some would say, creates) great heterogeneity and variability among individuals who receive these diagnoses. The main implication of this variability for the clinician is that knowing that a person carries a diagnosis of Alcohol Dependence reveals little about the details of the person's problems.

Within the Alcohol Use Disorders, there are two categories: Alcohol Abuse and Alcohol Dependence. The general criteria for these disorders are the same as the criteria for other Substance Use Disorders such as Cocaine Abuse, Heroin Dependence or Cannabis (marijuana) Abuse. All substances that create problems are presumed, in a sense, to create the same sorts of problems as each other. Within the *DSM-IV-TR* system, Abuse is presumed to be less severe, and at one time was thought to be a precursor to Dependence. However, a long-term study by psychiatrist George Vaillant of Harvard University found that people who

receive a diagnosis of Alcohol Abuse do not typically progress to Alcohol Dependence. Thus, while Alcohol Abuse is less severe (in that the negative consequences elaborated in the diagnosis are less impairing than those for Alcohol Dependence), there is some indication that Alcohol Abuse may be a different sort of disorder than Alcohol Dependence. It seems clear that they both fall along the continuum of alcohol problems defined by the Institute of Medicine, however the dividing line between the two disorders is not always clear.

With these preliminary comments in mind, we're now ready to consider the definitions themselves.

Alcohol Abuse

Alcohol Abuse requires that the person experience one or more of the problems outlined in the boxed material below within a 12-month period. This is usually considered to be the immediately preceding 12 months, but that is not necessary. So, a 45-year-old accountant who had two DWI arrests while in college, but no problems associated with alcohol in the past year, could appropriately be diagnosed with Alcohol Abuse. As we shall see with Alcohol Dependence, the "course" or time factors in the diagnosis have not been incorporated into the Alcohol Abuse diagnosis in as much detail as they are for Alcohol Dependence.

In addition to meeting one or more of the criteria for Alcohol Abuse, the person must also experience "clinically significant impairment or distress" as a result.

Far less is known about the course and prevalence of Alcohol Abuse than is known about Alcohol Dependence. This may be due, in part, to the fact that the people who seek help for alcohol-related problems have experienced far more severe problems than those associated with Alcohol Abuse and usually have a diagnosis of Alcohol Dependence, and it's the people in treatment who are the most accessible to researchers. In treatment settings, you will often find that clinicians use the terms Alcohol Abuse, Alcoholism, and Alcohol Dependence interchangeably, even though this is not correct.

THINGS TO REMEMBER

Criteria for Alcohol Abuse

I. (1 or more criteria for over 1 year)
   A. Role Impairment (e.g., failed work or home obligations)
   B. Hazardous use (e.g., driving while intoxicated)
   C. Legal problems related to alcohol use
   D. Social or interpersonal problems due to alcohol
II. Has never met criteria for Alcohol Dependence

THINGS TO REMEMBER

Criteria for Alcohol Dependence

I. Three or more of the following occurring at any time in the same 12-month period

A. Tolerance to the effects of alcohol as defined by either:

i. need for markedly increased amounts of alcohol to achieve desired effect

ii. markedly diminished effect with continued use of the same amount of alcohol

B. Withdrawal symptoms or use of alcohol to avoid withdrawal.

C. Alcohol is consumed in larger amounts or over longer time periods than was intended.

D. Presence of a persistent desire or unsuccessful attempts to cut down or control alcohol use.

E. A great deal of time is spent drinking, obtaining alcohol or recovering from the effects of drinking.

F. The person gives up important social, work or recreational activities in order to drink or as a result of drinking.

G. Alcohol use continues despite the person knowing that they have a persistent or recurring physical or psychological problem that is likely to be due to or made worse by drinking.

Alcohol Dependence

Alcohol Dependence is by far the most widely used diagnosis applied to people with alcohol problems. When most people think of clinically significant drinking problems, or of the label "alcoholic," they are thinking of problems of the sort that qualify for a diagnosis of Alcohol Dependence.

As with other substance-related disorders, in order to receive a diagnosis of Alcohol Dependence, the individual's drinking must create any of a number of problems.

As with Alcohol Abuse, the presence of these criteria in a client's life must create "clinically significant impairment or distress." The definition of "clinically significant" is never made clear in the *DSM* and this leaves lots of room for clinical judgment in applying the diagnosis. It is also easy to see that these criteria create a very heterogeneous group of people who qualify for a diagnosis of Alcohol Dependence. It is possible, for example, for a person to meet criteria A, B, and C, but not D, E, F, and G and still be diagnosed with Alcohol Dependence. It is also possible for a person to meet criteria E, F, and G, but not A, B, C, and D, and receive a diagnosis of Alcohol Dependence. In addition to the seven basic criteria, of which three must be met in order to receive a diagnosis of Alcohol Dependence,

THINGS TO REMEMBER

Alcohol Dependence Specifiers

I. With Physiological Dependence: either tolerance or withdrawal criterion is met.

II. Without Physiological Dependence: neither tolerance nor withdrawal criterion is met.

the *DSM-IV-TR* also includes two "Specifiers." This great variety of symptom and problem patterns among people who qualify for this diagnosis is often forgotten when we refer to people who have this diagnosis.

In practice, it is extremely rare to see someone who qualifies for an Alcohol Dependence diagnosis who does not warrant the qualifier "With Physiological Dependence." This is a result of the fact that virtually all regular users of alcohol develop some degree of tolerance to the effects of alcohol. While there is no hard and fast way of distinguishing this "normal" tolerance from "problem" tolerance, clinicians often use the rule of thumb that in order to diagnose "tolerance" the person must report needing at least 50% more alcohol than before to achieve the same effect or drink 50% more than before without any noticeable increase in effect. So, a person who routinely drank two drinks to achieve the "buzz," they preferred but found after a period of drinking that it now took three drinks to achieve the same "buzz" would meet the criterion for tolerance. If two other criteria of Alcohol Dependence were met, the person would receive a diagnosis of Alcohol Dependence with Physiological Dependence.

In yet another attempt to capture the dramatic variability and heterogeneity present in alcohol problems and problem drinkers, the *DSM-IV-TR* also provides what are called "Course Specifiers" for substance-related disorders.

The Course Specifiers, while intended to clarify the process of recovery from alcohol problems, are actually quite controversial when they are scrutinized. What they essentially imply is that a person can *never* fully recover from Alcohol Dependence. A person who returns to moderate and minimally symptomatic alcohol use still retains the diagnosis, despite the fact that his or her drinking no longer is problematic. Thus, once a person is diagnosed with Alcohol Dependence they have that diagnosis for life. While this is intended to capture the continued risk associated with a resumption of drinking for a person who has met the criteria for Alcohol Dependence, it does not adequately capture the range of possible problem resolutions that have been found by researchers—one of which is a return to moderate, non-harmful and non-dependent drinking. In fact, research suggests that this is a very common outcome among people who resolve drinking problems without treatment (probably the vast majority of people with drinking problems). This leads us to the next important topic for consideration in this chapter: the course of alcohol problems.

THINGS TO REMEMBER

Course Specifiers for Alcohol Dependence

I. Early Full Remission: At least one month, but less than a year in which no symptoms of Alcohol Dependence or Abuse are present.

II. Early Partial Remission: At least one month, but less than a year in which one or more symptoms of Alcohol Dependence or Abuse are present, but the person does not meet enough symptoms (3 or more) to qualify for the full diagnosis.

III. Sustained Full Remission: No symptoms of Alcohol Dependence or Abuse have been present for a year or more.

IV. Sustained Partial Remission: Full criteria for Alcohol Dependence or Abuse have not been met for a year or more, but one or more of the criteria for either Abuse or Dependence have been present.

Once a Drunk, Always a Drunk? The Course of Alcohol Problems

For many years it has been conventional wisdom, both among lay people and many professionals in the field, that alcohol problems, once initiated, will almost inevitably result in continued drinking of larger quantities, and the drinker will experience greater and greater problems with alcohol, eventually (again, almost inevitably) suffering severe medical and neurological problems, if not imprisonment and death. In fact, this idea of progressiveness was probably first delineated systematically in the late 18th century by the pioneering American physician Benjamin Rush, the father of American psychiatry and a signer of the Declaration of Independence, who developed what he called the "Moral Thermometer" of alcohol problems. While Rush linked "progression" of problems to the type of alcoholic beverage consumed, the implication is clear—as drinking gets worse, the consequences of drinking get worse, too.

The notion of progression has remained with us into the 21st century. In addition, the belief that alcohol problems are largely inherited has been a prominent idea in the popular and clinical conceptions of alcohol problems. However, research conducted on a variety of groups of problem drinkers (from adolescents and college students to adults) has consistently questioned both of these ideas.

The picture of "progression" that emerges most strongly from the research literature is that "progression" is rare among problem drinkers and that most problem drinkers resolve any problems they experience as a result of drinking. The question that might occur to you at this point is, "Well, what leads to resolution of alcohol problems?" The answer is as complex as the problems and the people who experience them. What does seem to be the case is that problems are most likely to resolve when the person experiences a significant shift in social

role expectations (i.e., graduates from high school or college and now must hold down a full-time job, a role that is incompatible with heavy drinking during the week) or life circumstances (i.e., becomes a parent for the first time). Other pathways to problem resolution include responding to expressed concerns by significant others, onset of medical problems with advice from one's physician to cut down or stop drinking, a change in social affiliations, or a geographic move. This list is not exhaustive, and it seems likely that there are as many triggers to resolution of alcohol problems as the people who experience them.

Another popular misconception related to the idea of progression is that once a person becomes alcohol dependent (or "alcoholic") he or she will virtually always and inevitably drink as much as he or she can under any circumstances where alcohol is available. In fact, research done in the early 1970s at Johns Hopkins and Rutgers universities shows clearly that this does not happen. In this research, alcohol dependent drinkers were provided unlimited access to alcohol under conditions in which they were housed in a medically supervised unit, and provided with adequate food and medical care. Although alcohol was made available in unlimited quantities (note that this research could not be done now due to regulations about protecting human subjects that were not in place when these studies were done), the subjects were also often required to engage in various tasks in order to obtain the alcohol. The tasks ranged from simple to fairly demanding, but all could produce, if the subject so chose, as much of the subject's preferred alcoholic beverage as desired.

Conventional wisdom suggests that, under these circumstances, these subjects would drink more and more and more until they passed out, and that the amounts they consumed each day would steadily increase. In fact, this is not what was found at all. Subjects tended to find a "comfort level" of consumption and remain there, not increasing their alcohol intake beyond that level. Likewise, they would often take "vacations" from drinking and not drink at all for several days or weeks. This research suggested that alcohol dependent people would not continuously escalate the amounts they drank and were able to exercise fairly precise control over how much they drank and when.

Just as researchers have questioned the notion of progression, so has the idea that alcohol problems are largely inherited. We all hear about entire families who appear to suffer from alcohol problems, but is this the exception rather than the rule? For years, researchers have searched for a specific genetic basis for alcohol problems, but the findings have been mixed at best. What seems to emerge most clearly from the volumes of research studies is that alcohol problems are heterogeneous in respect to genetic involvement. Some people have a clear genetic predisposition to develop alcohol problems, while others don't appear to have this genetic predisposition. When we look carefully at clinical populations, there are clearly many clients who appear to have no family history of alcohol problems, while others seem to have nothing but alcohol problems in their ancestral background. This "mixed bag" has led Marc Schuckit, a psychiatrist who has studied

the genetics of alcohol problems for years, to conclude that genetic factors are, at most, only half the story in the development of alcohol problems. While there appear to be some identifiable risk factors for problems with alcohol, these risk factors are not universal. For example, Schuckit's research has identified a group of children of alcohol-dependent parents who seem to have an innate tolerance to the effect of alcohol. They don't feel as intoxicated when they drink as do others, and this tolerance is present from the time they take their first drink. This allows them to drink more than their peers, but since they don't experience the same intensity of positive feelings from drinking they become prone to drink more in order to "keep up." This increases the likelihood that they will become dependent on alcohol, but not all the children of problem-drinking parents who show this characteristic actually develop drinking problems themselves.

What the research suggests, then, is that genetics and other biological factors increase the risk (or probability) that a particular individual will develop problems as a result of drinking. However, the best we can do with a particular person is to say they have a greater or lesser probability of developing problems based on their genetic and family heritage. We are unable to predict with any degree of certainty whether problems will actually occur. In all likelihood, that's because there is another significant variable in the development of alcohol problems: the environment.

It is clear that environmental influences also play a major role in the development of alcohol problems—at least as significant a role as genetic or biological factors. Such factors as cost and availability of alcohol, for example, play a major role in the nature and type of drinking problems that people develop. Using our own national example of the era of Prohibition in the 1920s and 1930s, the amount of alcohol consumed per capita dropped, as did the prevalence of alcohol-related medical problems such as cirrhosis of the liver. Unfortunately, other problems increased, particularly those associated with the fact that alcohol was illegal to make or use for "non-medicinal" purposes. This led to increased social and legal problems in the form of bootleggers and organized crime that capitalized on the scarcity of a product that was still in high demand.

Treat Me or Lose Me: Is Treatment Necessary to Resolve Alcohol Problems?

Related to the question of the progression or progressiveness of alcohol problems is the question of how most people who experience those problems get over them. It has almost become a mantra in our society that when alcohol and other drug problems reach a certain level of severity (albeit unspecified and, perhaps, unspecifiable), the sufferer will almost always require treatment in order to return to a healthier life that is free of negative consequences associated with drinking. In the 1970s and 1980s an entire industry developed in response to this

notion, and the "28 Day Rehab" became the approach of choice in many peoples' minds for helping people overcome problems with drinking. What does research say about this important question?

In the past 20 years, there has been more and more focus on what is termed "spontaneous remission" (or "natural" or "unassisted") recovery from alcohol problems. The notion of natural recovery was not new. In fact, Benjamin Rush, author of the Moral Thermometer, wrote about several such cases as early as 1795. The eventual focus on "natural" recovery was generated largely by the work of epidemiologists who were trying to understand the extent of alcohol problems in the American population. These researchers began to hear stories of people who, at one point in time, had experienced severe problems associated with drinking but later appeared to have stopped drinking without help, or to have reduced their drinking to safe amounts. Depending on the study and the particular population that investigators looked at, it became apparent that the majority of alcohol problems, including Alcohol Abuse and Alcohol Dependence, resolved without the individual seeking formal help of any kind. In fact, it appears that regardless of the drug of interest, people who develop problems with substance abuse are more likely to resolve them on their own than through treatment. This appears to be the case regardless of whether or not the person's substance problems reached a level that warranted a diagnosis.

To Quit or Not? How Do Most People Resolve Alcohol Problems?

Closely related to the notion that treatment is necessary to resolve most alcohol problems is the idea that the only way to effectively put an end to alcohol problems is to initiate and sustain lifelong abstinence from alcohol (and other psychoactive substances as well—with the exception of nicotine and caffeine). The same research that examined "natural" recovery also looked at how these people resolved their alcohol problems. Did most people quit altogether, or did most simply reduce their drinking to the point where they were no longer experiencing problems?

The data are somewhat mixed on this question. However, what is clear is that lifelong abstinence is not the most common resolution of alcohol problems. In fact, the folks who are pointed out as the shining stars of sobriety in meetings of Alcoholics Anonymous and have 10, 20, or 30 years or more of complete abstinence are the dramatic exceptions, rather than the rule. As with virtually everything else about alcohol problems, the actual facts differ quite a bit from popular perceptions and clinical suppositions.

Researchers have found that a final resolution of an alcohol problem takes many forms and depends, in part, on how the individual reached that resolution. There is also a suggestion that there may not be any such thing as a "once and

for all, end of story, final" resolution of alcohol problems, at least in terms of achieving lifelong abstinence, for most problem drinkers.

What is clear is that abstinence is a more common resolution among people who undergo treatment, while moderation of drinking to a point at which alcohol is no longer creating negative consequences or symptoms of Alcohol Abuse or Dependence, is the most common route to resolution for those people who resolve drinking problems without treatment.

Part of the confusion about resolution of alcohol problems has come from our focus on alcohol consumption itself as the touchstone characteristic of alcohol problems and their resolution. There has been an assumption (logical at some level, but incomplete) that if you want to get over a drinking problem the best way is simply not to drink—to "Just Say No!" Despite the simple logic of this notion—that a person must drink alcohol in order to suffer from a diagnosable alcohol problem—the symptoms of alcohol problems set down in the *DSM-IV-TR* (with the possible exception of withdrawal) have little direct relationship to the amount or frequency with which the individual drinks. It is largely, though not entirely, true that the more a person drinks, the more likely it is that he or she will experience problems as a result of that drinking. However, there are many, many examples of famous (Winston Churchill comes to mind) and not-so-famous people who drank very large amounts over long periods of time but seemed to suffer no ill effects. Again, the watchword is "heterogeneity." There is no such thing as a "typical" person with alcohol problems. Everyone's problems with alcohol are different from those of other problem drinkers.

Throughout modern history, the debate has raged over the better course of action to resolve alcohol problems: a focus on moderation or a focus on abstinence. In the United States, there have always been treatments and support groups guided by both courses of action. Most recently, Moderation Management (MM) has provided support for people who seek to resolve alcohol problems but who are not sure which is the most viable course for them—abstinence or moderation. The focus of MM is to provide support to any person who develops and implements a plan to resolve a drinking problem that best suits that individual, whether it's focused on abstinence or moderation. The fact of the matter is that we simply have no way to tell in advance who will be successful with which approach, although we do know that people who are strongly committed to one approach, regardless of whether it is abstinence or moderation, appear more likely to achieve their goal. In later chapters we will focus on this issue again, particularly in the context of how best to help people resolve alcohol problems in a lasting way. What is clearly emerging from the past 25 years of research on alcohol problems is that there is no one-size-fits-all answer when it comes to resolving problems associated with drinking.

Different Strokes for Different Folks: Recovery, Relapse, and the Future of Treatment

As our knowledge of the causes, course, and outcomes of alcohol problems has grown through research, the picture that emerges is one of far greater heterogeneity and variability than of uniformity and consistency. This has led, in recent years, to the notion of matching clients to treatments, encouraging alternative routes to resolution of alcohol problems, and an increasingly popular view (at least among researchers) that the best approach to take in understanding alcohol problems is "different strokes for different folks." This new approach reached its most recent zenith in the large-scale federally funded research project called Project M.A.T.C.H.

Project M.A.T.C.H. (M.A.T.C.H. stands for Matching Alcohol Treatment to Client Heterogeneity) grew directly out of research showing that there were lots of different ways that people resolve alcohol problems. The original goal was to define client characteristics (such as age, gender, duration and severity of drinking problems, personality variables, motivation, etc.) that would predict a better outcome from one of three treatments that were studied. While the researchers in this were unable to identify specific client characteristics (other than anger and resistance) that were associated with outcome, it seems likely that they were looking in the wrong place. Other research has clearly shown different outcomes for different approaches for different people. How Project M.A.T.C.H. failed to find matching characteristics will be a topic for discussion later on when we address specific treatments.

While Project M.A.T.C.H. failed to reach its specific goals, it did prove to be a stepping stone for the development of more broadly applicable approaches, and it opened the door for approaches that are less intensive and intrusive than traditional treatments. In particular, results of Project M.A.T.C.H. showed that a four-session Motivational Enhancement Treatment could produce outcomes comparable to two other 12-session approaches (one based on facilitating client involvement in AA, the other focusing on teaching specific cognitive and behavioral skills for recovery).

The future of treatment in this country is now one that is extremely open. Over the past 15 years, research has begun to have a significant impact on what treatment providers do, how they conceive of the best ways to help clients resolve alcohol problems, and the ways in which they approach the task of motivating and assisting change. Of particular importance is a growing recognition that there are many different pathways out of problems with alcohol, and that no single pathway will be appropriate for everyone. While this will almost certainly make it easier for clients and others who wish to get assistance without formal treatment to find an approach that works for them, it puts an increasing burden

on clinicians and counselors to be informed about the various approaches in order to help clients choose their own course. This more individualized approach puts greater pressure on providers to conduct assessments of clients in order to assist in treatment, intervention, and support planning. All of this requires more extensive training and credentialing of clinicians than ever before. It also makes it more difficult for potential clients to select the one that will best suit them.

Unfortunately, as the candy store gets more and more stock, the research that would help clinicians make explicit, helpful recommendations to clients and others who want to change their drinking habits, lags behind. In this book, we take an "experimental" approach to resolving alcohol problems. Based on research findings, we will suggest that the clinician's foremost role, at least in the beginning of a relationship with a client, is to help that client make informed decisions about an initial course of action. We will discuss at length some of the principles of this approach and the research that supports it.

As a preview, the approach we suggest is one that attempts to provide the three factors identified by psychologists Edward Deci and Richard Ryan that are necessary to foster lasting changes in behavior. The three factors are (1) *autonomy support,* an explicit acknowledgement of the client as an autonomous human being who will be the ultimate decision maker in any circumstance regarding drinking and its consequences, (2) a helping *relationship* that is characterized by intense respect for the client, empathy for the client's view of the world (although not necessarily agreement with it), and an emphasis on collaboration and active participation with the client in treatment planning and implementation, and finally (3) *competency enhancement* where necessary. That is, providing the client with opportunities to learn new skills, or rethink old ones, that will enhance movement toward the goals the client has committed to achieving.

Within this framework (abbreviated by the acronym ARC) assisting clients and others to make effective and lasting changes in their behavior in pursuit of a healthier life becomes much easier and less fraught with many of the pitfalls that clients encounter. This approach is based not only in research specific to alcohol problem resolution but on findings from the behavior change and motivational literatures generally. Most importantly, for both practitioners and the clients who make the effort to change problem drinking, we believe the ARC approach will greatly enhance their satisfaction with the outcomes.

Key Terms

Alcohol Abuse. A less serious form of *DSM-IV-TR* alcohol use disorder characterized by interpersonal, social, and vocational problems associated with alcohol abuse.

Alcohol Dependence. The more serious form of *DSM-IV-TR* alcohol use disorder characterized frequently by physical as well as behavioral and psychological symptoms. Often used synonymously with "alcoholic."

Course Specifiers. *DSM-IV-TR* criteria used to describe remission from alcohol use disorders.

Recommended Reading

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (text revision), by the American Psychiatric Association (Washington, DC: Author, 2000).

"Alcohol Use Disorders," by B. S. McCrady (2001), in *Clinical Handbook of Psychological Disorders, 3rd Edition,* edited by D. H. Barlow (pp. 376–433, New York: Guilford).

TRUTH OR FICTION

QUIZ ANSWERS

1. False 2. False 3. False 4. False