RETHINKING DRINKING

Rethinking Drinking:

A Client-Centered Approach to Alcohol Abstinence, Moderation, and Harm Reduction

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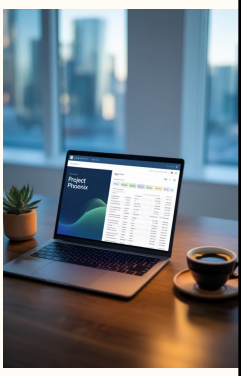

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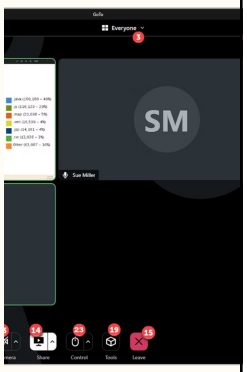

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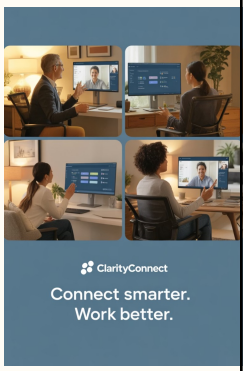

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- PDF of all slides in today's webinar
- Link to my textbook (2nd edition)
- New Patient Assessment Questionnaire
- Huffington Post Article "*Mindful Moderate Drinking*"
- Handout: 10 Tips to Moderate Your Drinking

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References and Suggested Reading

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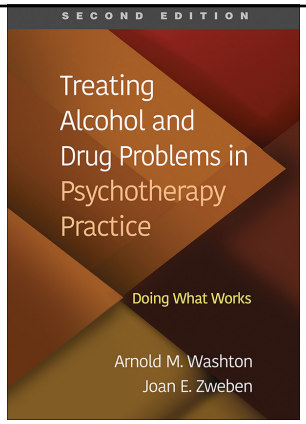

2nd Edition
Guilford Press, 2022

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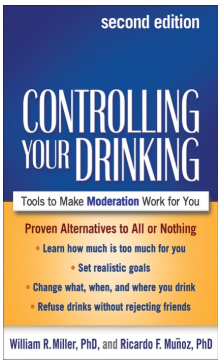

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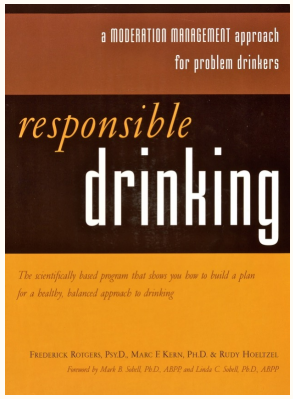

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New Harbinger: 2002

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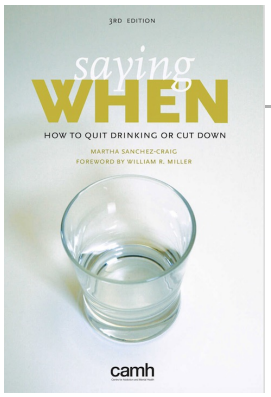

Martha Sanchez-Craig, Ph.D.
Toronto Addiction Research Foundation

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Saying When: How to quit drinking or cut down
Centre for Addiction and Mental Health (CAMH), Education

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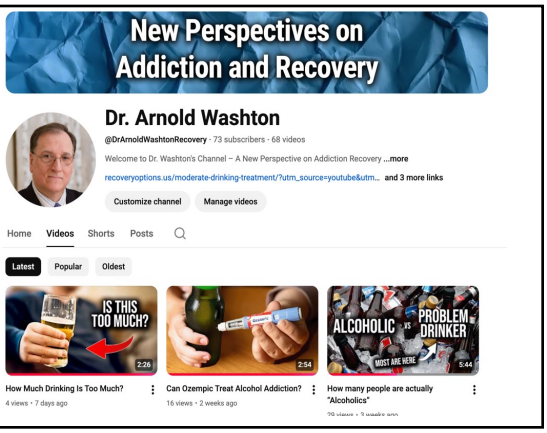

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Today's Objectives

- Describe a client-centered harm reduction approach for addressing a broad spectrum of alcohol problems in functional adults who are…
- Seeking help from mental health practitioners-- psychologists and others in office-based practice.
- Who are not necessarily specialists in treating addiction and in cases where alcohol may not necessarily be the primary or initial complaint for which the client is seeking your professional help.
- Summarize empirical research supporting moderation/harm reduction and traditional abstinence-based approaches

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Today's Objectives

Especially for those of you who are not addiction specialists:

- It is my hope that today's webinar encourages, motivates, and empowers you to address alcohol issues more routinely and more effectively in your psychotherapy practice rather forgo a valuable opportunity to address these issues because you may not have specialized training and expertise in treating SUDs.

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Recent Advances

- Two of the most important advances in the treatment of SUDS in recent years have been:
  - Emergence of harm reduction approaches as alternatives to traditional abstinence-only treatment. Markedly expands treatment options and encourages psychotherapist involvement
  - Availability of more effective medications and greater acceptance of medication-assisted treatments that integrate pharmacological and behavioral interventions in ways that enhance treatment engagement, retention, and positive outcomes. For alcohol, the most promising recent advance is the GLP-1 agonists- *Ozempic* (semaglutide) and *Mounjaro* (tirzepetide)
  - Increasing recognition of the need for psychotherapeutic interventions to address complex self-medication, emotional dysregulation, and trauma-related issues often intertwined with addictive behaviors

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The Psychotherapist's Role

Office-based therapists—especially those skilled in motivational interviewing, cognitive-behavioral therapy, and client-centered psychotherapy—can play a crucial role in moderation and harm reduction approaches.

This is particularly true for clients who are high-functioning or ambivalent about abstinence.

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You Already Have Most of What It Takes

- As a professionally-trained clinician, you already possess powerful therapeutic skills that translate directly to addressing substance use.
- You don't need to become an addiction specialist or return to graduate school. What you do need is foundational knowledge and confidence to apply your existing psychotherapeutic skills to this critical issue.
- Many clients seeking help for depression, anxiety, or relationship problems also struggle with substance use—often unaddressed because clinicians feel unprepared.
- As a competent psychotherapist it's important to recognize that you can adapt and expand your clinical skills to make a meaningful difference.
- Addiction psychotherapy can be a valuable and rewarding addition to your clinical practice.

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Why Psychotherapists are Critical in Addressing Substance Use Disorders

- **First Point of Contact:** Private practice therapists are often the initial healthcare providers sought by individuals with emerging substance use problems.
- **Trust and Confidentiality:** Professional clients particularly value the privacy and personalized care of office-based settings compared to specialized addiction centers.
- **Dual Diagnosis Expertise:** Mental health professionals are uniquely positioned to address both substance use and co-occurring psychological conditions simultaneously.

Psychotherapists in private practice settings have a unique opportunity to identify and address SUDs before they become increasingly severe and destructive. Your existing therapeutic relationship provides the foundation for effective intervention when substance use is identified as a problem.

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Applicability of psychotherapists' skills

- SUDs are fundamentally behavioral problems and "self-medication" disorders that obey the same laws as many other types of behavioral and psychological problems and are responsive to many of the same types of therapeutic interventions
- Non-specialists can learn how to adapt their clinical skills and expand their knowledge base to achieve greater proficiency in treating SUDs-- the goal of this workshop!
- Don't just reflexively tell patients to go to AA meetings or an IOP for help with an alcohol/drug problem because you simply don't deal with that in your practice.
- Express curiosity, look deeper, assess the patient's view of the problem and what might be helpful

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The Therapeutic Relationship is the Primary Vehicle for Change

Your most powerful tool isn't a protocol or assessment form—it's the therapeutic relationship itself. This alliance becomes the foundation for motivating and facilitating change around substance use, just as it does for other presenting concerns.

Build Trust First

Safety and non-judgment create openness to explore difficult topics like substance use

Start Where the Client Is

Your client's goals and readiness guide the pace and direction of intervention

Support Incremental Change

The relationship itself becomes a secure base for experimenting with new behaviors

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Two Philosophical Approaches to Substance Use Disorders

Understanding these contrasting frameworks helps you make informed choices about how to work with clients struggling with alcohol and drug problems.

Harm Reduction Approach

Philosophical roots: Rogerian client-centered therapy

- Meets clients where they are
- Accepts and reinforces incremental progress
- Prioritizes reducing risks and consequences
- Values any positive movement, despite setbacks
- Embraces moderation as valid start or goal
- Non-judgmental, motivational stance

Abstinence-Only Approach

Philosophical roots: AA disease model

- Requires acceptance of "alcoholic" identity
- Defines success as complete abstinence
- Views controlled use as denial-based illusion
- Emphasizes surrender and powerlessness
- Views setbacks, no matter how limited, as "relapse"
- May encourage strong confrontation ("interventions")

Both approaches can be valuable. Harm reduction offers flexibility for clients not ready for abstinence, while abstinence may be medically necessary for some. Client needs and preferences should guide your approach.

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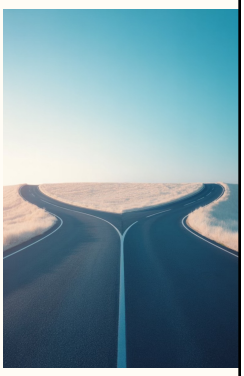
Two Paradigms of Alcohol Treatment

Understanding both the disease model and contemporary harm reduction approaches allows you to meet clients where they are and work with them collaboratively to achieve their self-selected treatment goals.



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The Disease Model of Addiction

The foundation of Alcoholics Anonymous and traditional abstinence-based treatment approaches.

Chronic Disease

Alcoholism is viewed as a progressive, chronic disease that cannot be cured, only arrested.

Loss of Control

Once drinking begins, the person cannot reliably control the amount consumed.

Abstinence Required

Complete abstinence is the only safe and effective goal for recovery.

Mutual Support

Recovery requires ongoing participation in support groups like AA and working the 12 steps.

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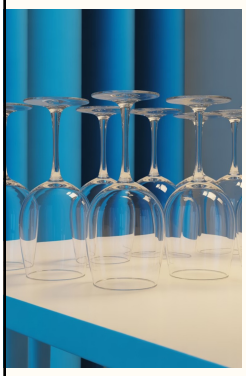

Abstinence-Based Treatment Rationale

> The only way to manage the disease is through complete and lifelong abstinence from all alcohol."

This model emphasizes that attempting moderation is dangerous and will inevitably lead to relapse and progression of the disease.

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Contemporary Harm Reduction Model

A more flexible, individualized approach that views alcohol problems as existing on a spectrum.

Spectrum Disorder

Alcohol problems vary widely in severity, from risky drinking to severe dependence.

Continuum of Severity

Problems exist along dimensions of consumption, compulsivity, impaired control, and consequences.

Individualized Goals

Treatment goals range from abstinence to reduced drinking to truly moderate consumption.

Collaborative Approach

Goals are formulated collaboratively with clients, not imposed unilaterally by clinicians.

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The Moderation Controversy: Examining Both Sides

Disease Model "Abstinence Only" Perspective

Core Belief: Alcoholism is a progressive disease requiring lifelong abstinence

- Any drinking goal short of abstinence is dangerous
- Controlled drinking is unrealistic for alcoholics
- Moderation attempts delay necessary abstinence
- Based on AA philosophy and tradition

Harm Reduction and Moderation Perspective

Core Belief: Not everyone with drinking problems has the same needs

- Problem drinkers are heterogeneous
- Abstinence-only approach turns away treatable individuals
- Lower barriers increase treatment access
- Client choice drives engagement and outcomes

The reality: **Neither side is absolutely correct**. The critical issue is offering treatment options that lower barriers and serve a broader range of individuals who could benefit from professional help.

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Moderation as Strategic Starting Point

Not an Ideology, But a Strategy

Offering help with moderation isn't a claim it's realistic for everyone. It's a therapeutic strategy designed to engage ambivalent individuals and reduce resistance.

The critical question isn't whether someone wants to drink moderately, but whether they're actually capable of doing so consistently.

For those with physical dependence, life-damaging consequences, or high-risk behaviors, abstinence is clearly the safest option. But for others, moderation-focused treatment often serves as a therapeutic bridge to acceptance and positive change.

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Harm Reduction

- Rooted in the principles and practices of Rogerian client-centered psychotherapy
- HR is a flexible, pragmatic, evidence-based approach that meets patients "where they are" in terms of their readiness to change
- Respects the client's autonomy to choose his/her treatment goals
- Encourages clinicians to work collaboratively with clients to guide and support them in pursuing their self-selected goals ranging from less harmful use to total abstinence
- For clinicians with little or no formal training in treating SUDs, this fundamentally non-confrontational psychotherapeutic approach incorporates many of the principles and techniques that all well-trained therapists already have in their clinical toolbox—the basic ingredients of all good psychotherapy!

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Basic Harm Reduction Philosophy

- Regardless of problem severity, any steps taken to reduce the risks and consequences of substance use (and other risky behaviors) are steps taken in the right direction
- Supports and encourages even the smallest positive steps in a spirit of optimism and curiosity without judgement or coercion
- Acknowledges and respects the fundamental principle that human behavior change is typically an incremental non-linear process that involves both progress and setbacks toward achieving a desired goal within an unpredictable time course

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SUD's are SPECTRUM disorders

- Do not fit neatly into well-defined diagnostic categories
- Vary along several interrelated dimensions:
  - Consumption Level (amount/frequency/pattern/chronicity of use)
  - Psychosocial consequences
  - Medical/physiological consequences
  - Compulsivity/pre-occupation/loss of volitional control
- DSM-V general severity rating MILD, MODERATE, or SEVERE-based on how many of 11 diagnostic criteria are met
- The terms "alcoholism" and "addiction" do not exist in DSM or ICD as diagnoses

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SUD's are SPECTRUM disorders

- Treatment planning should NOT be driven by diagnosis, but by assessment of what the patient wants, is ready to make use of, and what type of help you can offer
- This is especially true because (DSM 5) diagnostic criteria for SUDs are broadly and subjectively defined
- The common assumption that more severe SUDs automatically warrant higher or more intensive levels of care is not supported by empirical evidence

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SUDs are "Self- Medication" Disorders

- They are psychological/behavioral disorders, not simply medical/biological disorders
  - Substances acquire "super reinforcement" value when used as coping tools to attenuate negative affects or amplify desired behaviors
  - SUDs never develop in a vacuum, but always in the context of a person's psyche and life
  - Substance use takes on multiple roles and meanings in a person's life, which often change over time

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Uncovering What Substance Use Masks (Role as "Self-Medication")

Addressing substance use opens doors to understanding and treating underlying emotional and psychological issues that have been buried or masked by ongoing "self-medication" with alcohol/drugs.

Common issues that emerge during treatment:

- Unprocessed trauma and PTSD symptoms
- Chronic shame and low self-worth
- Difficulty tolerating emotions
- Relationship attachment wounds
- Avoidance of existential concerns

As substance use decreases, these underlying issues percolate or sometimes erupt to the surface and become available for therapeutic work—creating new vistas for healing.

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Psychological Functions of Alcohol

Affect Regulation
Dulling anxiety, loneliness, or self-critical thought

Social Facilitation
Providing relief from social inhibition or performance pressure

Decompression
Signaling transitions, such as "work mode off"

Identity Support
Reinforcing belonging or adult autonomy

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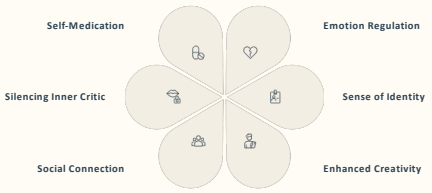
Psychodynamic Issues: The Multiple Roles and Meanings of Substance Use



Given these positive roles, the desire to moderate without stopping completely is understandably more appealing than total abstinence. Reduced use provides opportunity to explore these functions before considering giving up substances.

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Rationale for Harm Reduction

- Most problem drinkers:
  - Are not alcohol-dependent ("alcoholic")
  - Do not want to stop drinking completely and/or permanently
  - Lifelong abstinence is not their goal
  - Do not see their problem as a disease
  - Reject the identity of "addict-alcoholic"
  - Perceive their problem as not severe enough to warrant what traditional treatment requires

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Rationale for Harm Reduction

- Abstinence is without question the safest course
- Most people who seek help for alcohol problems do not want to give up alcohol completely.
- They are hoping to find a way to reduce their drinking so it no longer causes problems for themselves and others.
- Abstinence for life is not their goal.
- Their "off switch" for drinking has become unreliable or completely disabled and are hoping treatment can help to restore it

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Rationale for Harm Reduction

- Getting into debates and power struggles with clients about the necessity of total abstinence is not only off-putting and countertherapeutic, but misses a valuable opportunity to engage clients "where they are" and to increase their motivation/readiness for change
- Offering to help clients learn how to more safely manage their drinking as a first step toward addressing the problem is an extremely powerful and valuable engagement strategy that has significant therapeutic value whether or not total abstinence becomes their ultimate goal

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Rationale for Harm Reduction Approach

- Countless people with less severe alcohol problems routinely avoid treatment not seeing themselves as needing or wanting what traditional abstinence-based disease model treatment offers
- Lacking attractive treatment alternatives, their untreated alcohol problem and its consequences are likely to continue and get worse
- Current treatment system geared mainly toward people with high-severity problems
- Clients with less severe and earlier-stage problems are likely to be seen by traditional providers as resistant, unmotivated, and in denial

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Rationale for Harm Reduction

A professionally-guided attempt at moderation is often the best way for clients with alcohol problems to learn through their own experience whether moderation is a realistic goal or abstinence is a better choice.

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Value of Harm Reduction

- Whether patients ultimately choose moderation or abstinence, the Harm Reduction approach teaches valuable skills: self-monitoring, identifying triggers, managing urges, making deliberate choices, and recognizing when change is needed. These skills serve patients well regardless of their ultimate path.
- The goal is not to promote moderate drinking over abstinence, but to ensure that all problem drinkers have access to evidence-based treatment that matches their needs, readiness, and circumstances. In expanding options, we expand the reach and effectiveness of alcohol treatment overall.

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"Moderate Drinking" is only one of many Harm Reduction Goals

- "Moderate" drinking (however defined) is only one of many possible harm reduction goals
- Harm reduction pertains to ANY steps taken to reduce the risks and consequences of substance use and other potentially harmful behaviors
- Harm reduction goals range from total abstinence to any change in substance use (frequency, intensity, setting, etc.) that reduces the risks of causing harmful consequences to self and others
- The fundamental goal is to help clients change their relationship with alcohol

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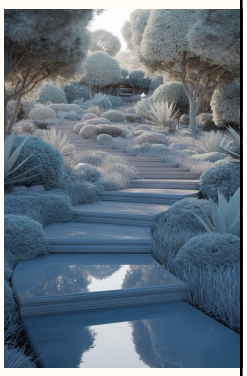
The Stepping-Stone Effect

Perhaps the most valuable aspect of harm reduction: it opens doors and creates pathways to recovery that might never have existed otherwise.

> "Many clients with severe AUDs enter treatment only because moderation options were available. Once engaged, some discover abstinence is necessary and transition successfully—a journey they never would have begun if abstinence-only was their only choice."

Harm reduction doesn't just reduce harm—it expands access, builds engagement, and creates multiple pathways to wellness.



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Why Moderation Often Leads to Abstinence

Real-World Experience
Individuals discover moderating is harder than anticipated through lived experience, not lectures.

Psychological Ownership
The decision carries greater durability because it makes sense to them personally.

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Self-Selected Conclusion
Abstinence emerges as their choice rather than an externally imposed rule.

Intrinsic Motivation
Abstinence becomes empowering—not deprivation, but a deliberate choice for well-being.

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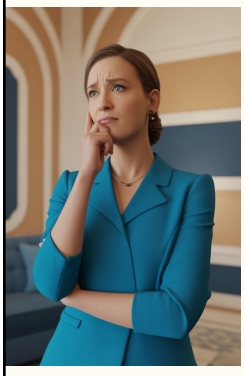

Is it irresponsible ("enabling") to offer moderation goals to people with severe drinking problems?

Traditional Perspective
Abstinence-only views consider offering moderation to heavy drinkers as enabling and potentially harmful, delaying necessary abstinence.

Client-Centered Reality
Many clients cannot or will not commit to immediate abstinence. Offering moderation or harm reduction as initial goals can increase engagement, reduce risks, and open doors for future abstinence.

Professional Nuance
Responsible practice demands thorough assessment, shared decision-making, and continuous monitoring. Goals remain flexible, adjusting if moderation becomes unsustainable or harmful.

Preserve Relationship and Do No Harm
The therapeutic relationship is paramount. Imposing abstinence-only goals prematurely can rupture trust, leading to disengagement. Flexible options foster trust and allow for future progress towards abstinence.

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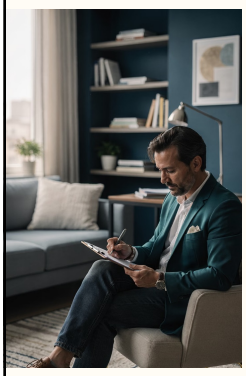

The Therapist's Countertransference

Alcohol discussions can evoke countertransference reactions depending on the clinician's personal relationship with alcohol–social moderate drinker, heavy drinker, abstaining for health/religious reasons or prior alcohol dependence.

Reflection on one's own attitudes toward substance use can enhance effectiveness. Supervision, peer consultation, or continuing education in harm reduction models can provide containment for these reactions and enhance your clinical competence with a broader range of substance-using clients

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Empirical Support

What Does the Research Show?

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Recent Studies Comparing Clinical Outcomes with Abstinence-Based vs Harm Reduction Treatment of Alcohol Use Disorders

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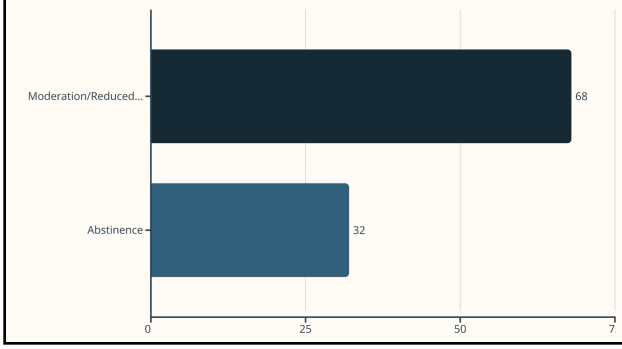
Patient Preference for Treatment Goals



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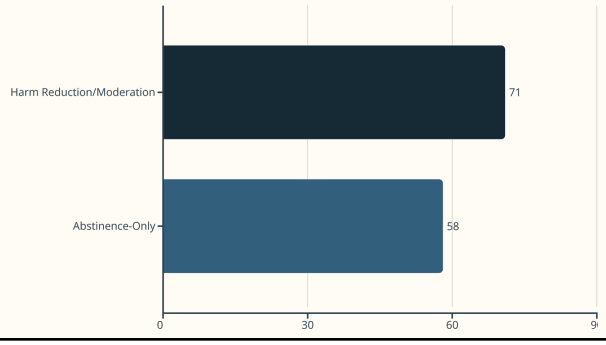
Treatment Retention Rates



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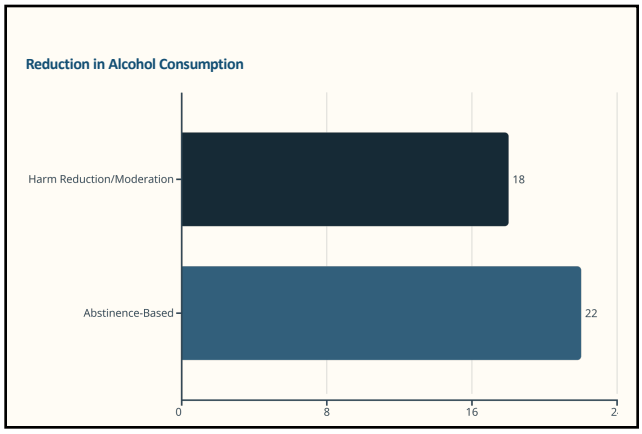

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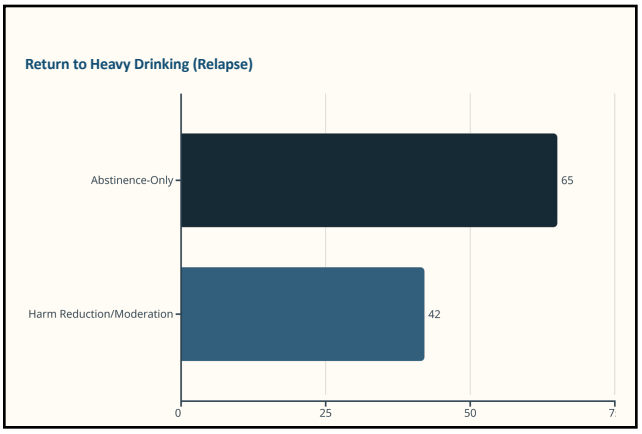

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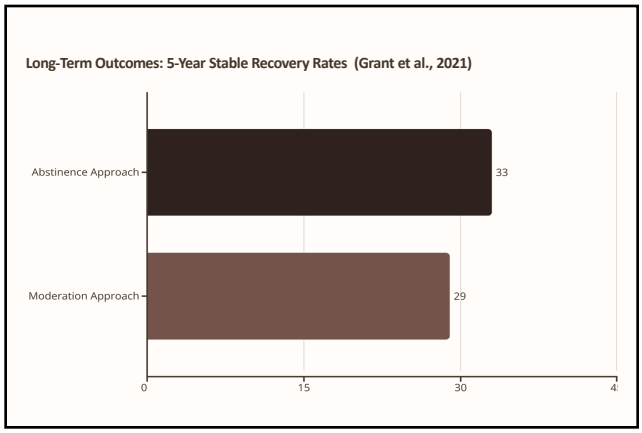

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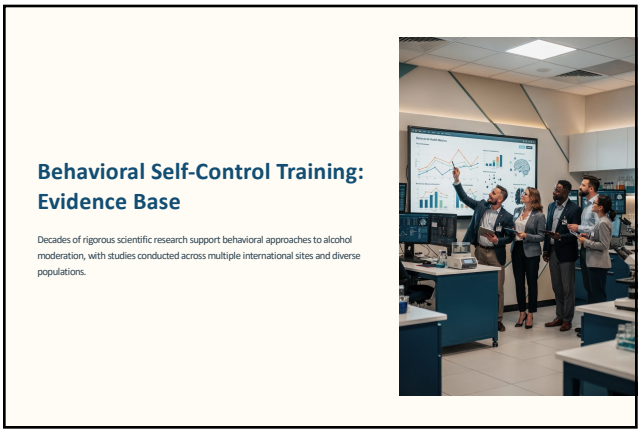

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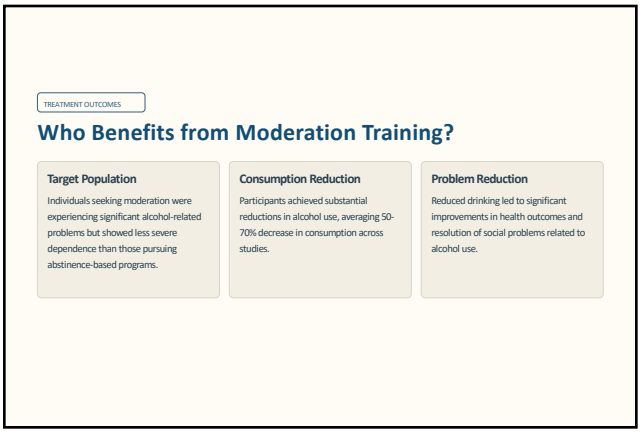

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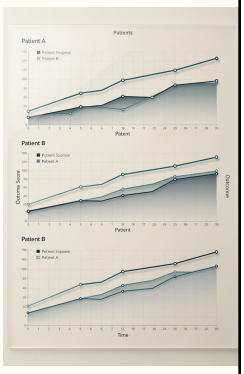
Five Moderation Trajectories at One Year

Miller & Munoz (2013) identified five distinct outcome patterns among individuals who attempted moderation training, revealing the diverse paths people take when working toward controlled drinking.



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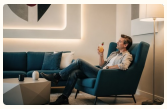
Successful Moderation Patterns



Stable Moderation (15%)

Moderation became effortless and comfortable. Individuals could take or leave alcohol, with drinking losing its central importance. They occasionally abstained completely or had one or two drinks without craving more.

Pretty Good Moderation (23%)

Substantial reduction in drinking with occasional lapses. Some days of excess drinking still occurred, with minor problems emerging periodically—but nothing like before. Generally satisfied with progress while aspiring to more consistency.

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Pathways to Abstinence

1. **White-Knuckle Moderation**
   Constant struggle to maintain control despite reduced consumption. Required ongoing effort without becoming easier over time. Ultimately decided abstinence was less exhausting than the "wrestling match" of moderation.
2. **Pointless Moderation**
   Successfully moderated but questioned the purpose of minimal drinking. Previously drank for intoxication; controlled drinking removed alcohol's appeal and meaning. Gradually tapered until alcohol became irrelevant.
3. **Nice Try Moderation**
   Genuine effort with limited success. Alternated between periods of moderation and heavy drinking. The experience helped them recognize that abstinence was the better choice to prevent further harm.

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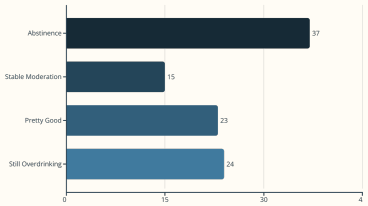
One-Year Statistical Outcomes



At one-year follow-up, 38% achieved successful moderation (stable or pretty good), while 37% chose abstinence—often after initially attempting moderation. Approximately one-quarter continued to struggle with overdrinking.

These findings underscore that attempting moderation can be a valuable step even for those who ultimately choose abstinence, as the experience clarifies the most sustainable path forward.

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LONG-TERM FOLLOW-UP

Predictors of Long-Term Success

Follow-up studies extending up to 8 years revealed critical patterns in sustained success:

- Individuals with **less severe alcohol problems** at baseline were most successful at maintaining problem-free moderate drinking over time
- Many with **more severe initial problems** succeeded with moderation temporarily but eventually transitioned to complete abstinence
- Approximately **25% of moderation attempters** ultimately chose abstinence as their long-term strategy

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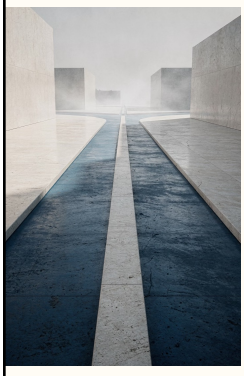

Treatment Goals and Natural Outcomes

Research reveals a fascinating pattern: individuals gravitate toward the approach that best fits their severity level, regardless of initial treatment goal.

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Key Research Findings

Severely Dependent

When successful, most often achieve abstinence—regardless of whether they initially pursued moderation or abstinence goals

Problem Drinkers

When successful, most often maintain moderate drinking—regardless of whether they initially pursued moderation or abstinence goals

Clinical Implication

Initial treatment goals have minimal long-term impact; individuals naturally find their optimal path based on problem severity

This self-matching phenomenon suggests that offering moderation as an option allows individuals to discover through experience which approach—controlled drinking or abstinence—is most sustainable for their circumstances.

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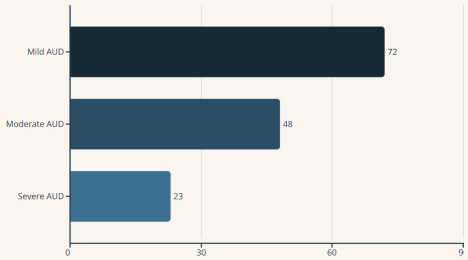
Moderation Success by Severity



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Who Succeeds with Moderation?

Good Prognosis Indicators

- Mild to moderate AUD severity
- Shorter duration of problem drinking
- Strong social support
- Stable employment and housing
- No severe medical complications
- High self-efficacy and motivation
- Good emotional regulation skills

Challenging Prognosis Indicators

- Severe AUD with physical dependence
- Long history of heavy drinking
- Multiple failed moderation attempts
- Serious medical consequences (liver disease, pancreatitis)
- Co-occurring severe mental illness
- Legal mandates requiring abstinence
- Pregnancy or planning pregnancy

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Additional Success Factors

Self-Efficacy

Reasonable confidence in one's ability to reduce consumption to safer levels enhances outcomes

Motivation to Learn

Willingness to invest time and effort in learning and applying behavioral self-control strategies

Life Stability

Absence of current crises—divorce, illness, job loss, financial distress—that compromise coping capacity

Psychological Health

No severe psychiatric illness or significant impairment in psychosocial functioning

No Other Drug Dependence

No history of dependence on drugs other than alcohol

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Research Insight: The "Initial Break" Advantage

A foundational study by Tucker and King (1999) on changing addictive behavior revealed a powerful predictor for successful moderation: taking an initial, intentional break from alcohol. This period of abstinence offers several critical benefits for those aiming to moderate their consumption.

Brain Reset

Allows the body and brain to recover from the immediate effects of regular drinking, reducing physical dependence and intense cravings.

Enhanced Clarity

Provides a period of clear-headedness to objectively assess drinking patterns, identify triggers, and reflect on the role of alcohol in one's life.

Builds Self-Efficacy

Successfully navigating a period of abstinence, even brief, builds confidence and demonstrates to the individual that they *can* exert control over their drinking.

Establishes a Baseline

Creates a clear starting point for moderate drinking, making it easier to notice the effects of even small amounts of alcohol and adhere to new limits.

Informed Decision-Making

Clients can make more conscious choices about their moderation goals and strategies after experiencing a period without alcohol.

Break 'Autopilot' Pattern

Interrupts habitual drinking behaviors, creating an opportunity to develop new, more intentional choices around alcohol consumption.

This research suggests that incorporating a structured period of abstinence can significantly improve the chances of long-term moderation success.

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ALCOHOL USE ASSESSMENT

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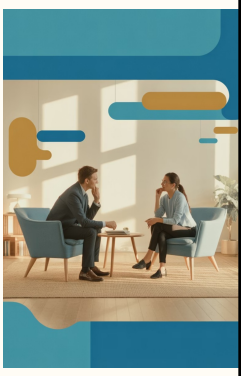
Assessment as the Start of Treatment

Assessment is not merely data collection; it's a dynamic intervention. It serves as a crucial entry point for treatment engagement, a powerful tool for motivation enhancement, and the foundational act of rapport and trust building, initiating the therapeutic alliance.



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Assessment: More Than Just Data Gathering

Assessment is a dynamic and therapeutic intervention, setting a crucial tone for the entire treatment journey.

Builds Therapeutic Alliance
The initial assessment is a critical opportunity to establish rapport, build trust, and initiate a strong working relationship between client and therapist.

Catalyzes Engagement
It serves as an entry point for treatment, drawing clients in and demonstrating that their concerns are heard and valued, fostering early engagement.

Fosters Motivation & Hope
Through empathetic inquiry, assessment can express optimism and hope, enhancing a client's motivation and readiness for change.

Empowers Client-Centered Progress
It allows you to meet clients "where they are," demonstrating acceptance and empowering them to guide their own positive change journey.

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Key Assessment Areas

Drinking Patterns
Quantity, frequency, duration, progression over time, periods of abstinence or control

Consequences
Physical health, mental health, relationships, work/school, legal, financial impacts

Psychological Factors
Co-occurring disorders, trauma history, stress, coping skills, emotional regulation

Social Context
Family history, social support, drinking culture in peer group, relationship dynamics

Motivation & Goals
Reasons for change, ambivalence, preferred outcomes, readiness to take action

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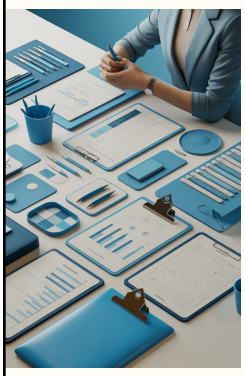

Assessment Tools

Clinical Interview
A comprehensive discussion to gather personal history, drinking patterns, consequences, and motivation.

The Washton Group New Patient Questionnaire
A detailed self-report instrument from the Washton Group, available for download at thewashtongroup.com.

Alcohol Use Disorders Test (AUDIT)
A 10-item screening tool developed by the WHO to identify hazardous and harmful alcohol consumption.

DSM-5 Criteria
Utilized to identify the presence and severity of Alcohol Use Disorder based on diagnostic standards.

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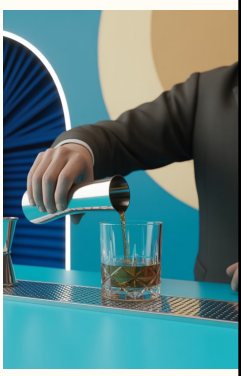
Defining "A Drink"

Standard drink definitions and alcohol "equivalents"



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What Counts as One Standard Drink?

Beer
12 oz at 5% alcohol

Wine
5 oz at 12% alcohol

Distilled Spirits
1.5 oz at 40% alcohol (80 proof)

Martini
Typically **2-3 standard drinks**

Each serving contains approximately 12 grams of ethyl alcohol. Many people underestimate their consumption by not recognizing these equivalents.

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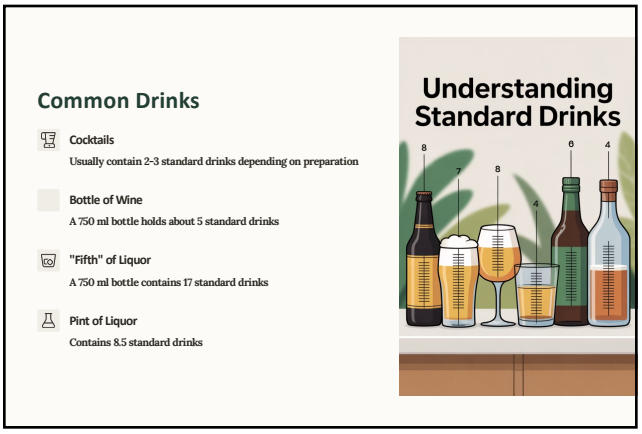

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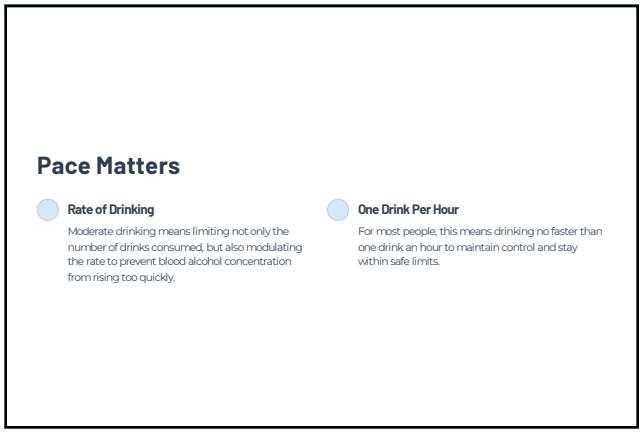

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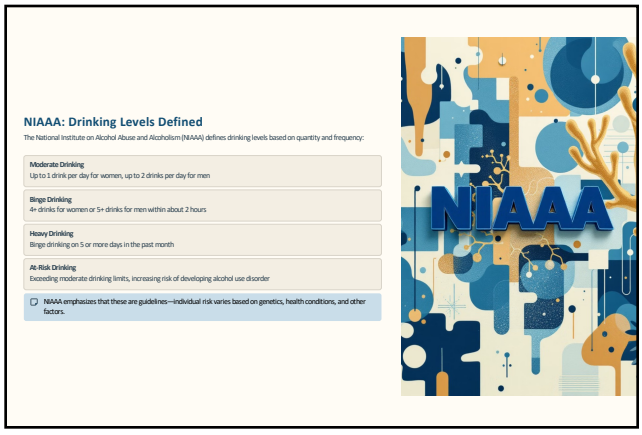

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DSM-5: Alcohol Use Disorder

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) replaced the terms "alcohol abuse" and "alcohol dependence" with a single diagnosis: Alcohol Use Disorder (AUD).

Severity Levels Based on Symptoms

1	Mild	2-3 symptoms
2	Moderate	4-5 symptoms
3	Severe	6+ symptoms

11 Diagnostic Criteria (meeting 2+ in 12 months indicates AUD)

- Drinking more or longer than intended
- Unsuccessful efforts to cut down
- Significant time spent obtaining/using/recovering
- Craving or strong urge to drink
- Failure to fulfill major obligations
- Continued use despite social/interpersonal problems
- Giving up important activities
- Use in physically hazardous situations
- Continued use despite physical/psychological problems
- Tolerance (need more to achieve effect)
- Withdrawal symptoms

DSM-5's dimensional approach recognizes that alcohol problems exist on a continuum, not as binary categories.

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NIAAA "Low Risk" Drinking UPPER Limits

The National Institute on Alcohol Abuse and Alcoholism provides clear guidelines for low-risk drinking limits.

Low-Risk Limits for Men	Low-Risk Limits for Women
No more than **4 drinks** on any single day	No more than **3 drinks** on any single day
No more than **14 drinks** per week	No more than **7 drinks** per week

Exceeding these limits increases risk for developing alcohol-related problems and alcohol use disorder.

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NIAAA Drinking Categories

Low-Risk Drinking
Men: ≤4 drinks/day, ≤14/weekWomen: ≤3 drinks/day, ≤7/week

At-Risk Drinking
Exceeds low-risk limits but no AUD diagnosis

Heavy Drinking
5+ drinks/day (men) or 4+ (women) on 5+ days/month

Binge Drinking
5+ drinks (men) or 4+ (women) within 2 hours

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DSM-5 Alcohol Use Disorder Criteria

AUD is diagnosed when at least 2 of 11 criteria are met within a 12-month period.

Impaired Control
- Drinking more or longer than intended
- Unsuccessful efforts to cut down
- Great deal of time obtaining, using, recovering
- Craving or strong urge to drink

Social Impairment
- Failure to fulfill major obligations
- Continued use despite social problems
- Important activities given up

Risky Use
- Use in hazardous situations
- Continued use despite physical/psychological problems

Pharmacological
- Tolerance (need more for effect)
- Withdrawal symptoms

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DSM-5 Severity Ratings

Mild AUD
2-3 criteria met

Moderate AUD
4-5 criteria met

Severe AUD
6 or more criteria met

Severity ratings help guide treatment intensity but should not dictate drinking goals, which must be individualized.

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Assessing Current Drinking Patterns

Understanding the nuances of a client's alcohol use pattern is crucial for tailoring effective interventions, whether for moderation or abstinence. A thorough assessment identifies triggers, functions, and risks associated with each pattern.

Daily Drinking (Physically Dependent)
Consistent daily consumption often characterized by physiological withdrawal symptoms upon cessation.

Daily Drinking (Non-Dependent)
Regular daily alcohol intake without developing physical dependence or overt withdrawal symptoms.

Alternating Patterns
Periods of heavy drinking interspersed with days of lighter consumption, or intentional fluctuation.

Weekend Binge Drinking
Concentrated heavy drinking primarily during weekends or specific days off from work/responsibilities.

Situational Binge Drinking
Heavy alcohol use occurring specifically in certain social contexts, events, or environmental triggers.

Emotionally-Triggered
Drinking used as a self-medication strategy in response to emotional distress, anxiety, or other triggers.

Sporadic/Periodic Binge
Infrequent, intense drinking episodes followed by extended periods of low or no consumption.

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Current Drinking

- What does your current drinking pattern look like?
- When, where, with whom are you most likely to drink moderately vs. excessively?
- How much is “too much” drinking for you
- What are the positive benefits of drinking for you? How does it help you?
- What are risks and consequences of your drinking?
- How do others view your drinking?
- Is your drinking connected with other drug use, sex, gambling, spending, etc.?

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Activators of Overdrinking

Drinking to cope with negative feelings
Such as boredom, anger, loneliness, or despair. Alcohol can be used as a temporary escape or numbing agent.

Drinking for pleasure/social reasons
Associated with positive events like parties, celebrations, or specific drinking “buddies” and social gatherings.

Drinking out of habit or routine
Triggered by specific times of day or week, certain places, social cues, or holidays where drinking has become an ingrained ritual.

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Understanding the "Why Now?" Question

1. **Crisis Precipitants**
   Often, clients seek help following a crisis or negative consequence related to cocaine use. Understanding these precipitating events provides insight into the client's motivation and immediate concerns.
2. **Accumulating Consequences**
   For many clients, the decision to seek help comes after a gradual accumulation of negative consequences across various life domains, reaching a tipping point where the costs of continued use outweigh the benefits.
3. **External Pressure**
   Some clients seek treatment due to pressure from employers, partners, or family members. Understanding these external motivators helps gauge intrinsic motivation and identify potential supports or barriers to change.

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ALCOHOL: The Good vs. Not-So-Good

Relaxation	Poor sleep quality
Social confidence	Morning fatigue
Stress reduction	Impaired decision making
Enjoyable taste	Health concerns
Social bonding	Financial costs

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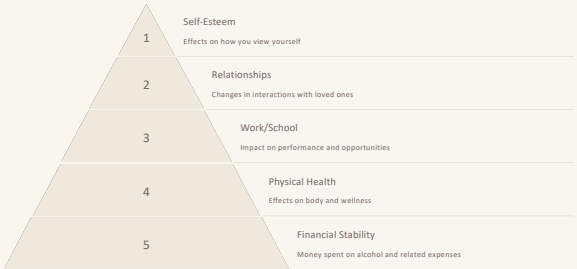
Alcohol's Impact on Your Life



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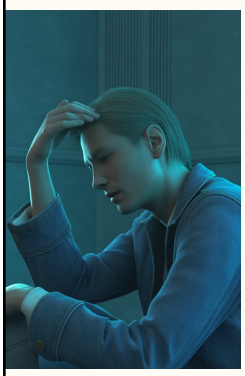

What's the worst thing that's ever happened to you due to drinking?

This pivotal question helps uncover the true depth of negative consequences and can serve as a powerful motivator for change. It prompts clients to confront painful realities, often revealing the 'rock bottom' moments that initiate their desire for help. This insight is crucial for understanding their current motivation and tailoring interventions.

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What You Like About Drinking

- **Psychological Effects**
  Does alcohol help you relax? Feel more confident? Escape worries?
- **Social Benefits**
  Does drinking help you connect with others? Feel part of a group?
- **Sensory Pleasures**
  Do you enjoy the taste? The ritual of preparing drinks?
- **Cultural Aspects**
  Is drinking tied to your cultural identity or traditions?

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Acknowledging What Drinking Provides

Clients often feel surprised and validated when clinicians openly acknowledge alcohol's positive functions. This creates therapeutic alliance and demonstrates genuine understanding.

Therapeutic statements that build rapport:

- "It makes sense that you're reluctant to give up something that helps you relax and connect with friends."
- "Alcohol has been your go-to stress reliever. Of course you're concerned about how you'll cope without it."
- "I can see why this is hard—drinking is woven into your social life, your business relationships, your identity."

This validation doesn't endorse continued problematic drinking—it acknowledges reality and builds trust.

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Reframing the Role of Alcohol

Beyond immediate triggers, we explore the perceived benefits of alcohol and imagine a future with reduced or no consumption.

How Does Alcohol Help You?

Consider the perceived positive functions alcohol serves in your life, even if temporary. Does it help with stress, social anxiety, sleep, or mood regulation? What needs does it appear to meet?

Imagining a Different Future

How would your quality of life be affected if you substantially cut back on your drinking or stopped altogether? Think about potential changes in health, relationships, finances, and emotional well-being.

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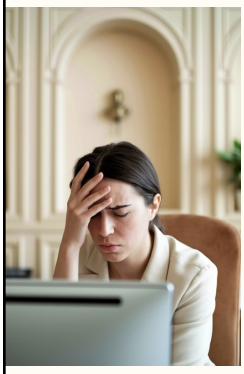

Identifying Your Triggers

- **Emotional Triggers**
  Stress, anxiety, loneliness, boredom, celebration, or sadness can trigger drinking.
- **Social Triggers**
  Certain friends, family gatherings, work events, or parties may activate drinking.
- **Environmental Triggers**
  Specific locations, times of day, or activities might cue your desire to drink.
- **Internal Triggers**
  Thoughts, memories, or physical sensations can spark drinking urges.

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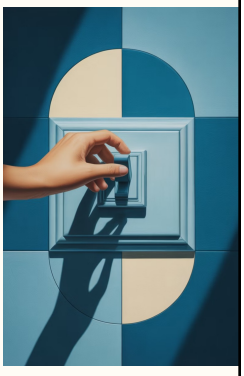
How Many Drinks Disable Your "Off Switch"?

The "off switch" refers to the brain's capacity to regulate and cease drinking, even when an individual intends to have only a few. Alcohol directly impacts judgment and impulse control, making it increasingly difficult to stop once consumption begins.

The exact number of drinks that disables this crucial mechanism varies significantly between individuals. Factors such as tolerance, body weight, metabolism, and emotional state all play a critical role. For many, even a few drinks can significantly impair this internal governor, leading to unintended excessive consumption.



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Unreliable "Off" Switch

- How many drinks does it take before you lose your "off switch"?
- How often does this happen in terms of percentage of times you drink at all?
- What factors help you to stop short of hitting this threshold?
- What factors lead you to drink past or override your "off switch?

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Binge Drinking

- The most common and often the most difficult pattern to break
- High-intensity, prolonged drinking episodes that span days/weeks during which enormous quantities of alcohol are consumed
- Often associated with disappearance, nowhere to be found by family/friends
- Often cause blackouts—amnesia for some/all of the drinking episode

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Binge Drinking

- Followed by severe hangovers, shame, guilt, remorse, anxiety- but usually no alcohol withdrawal symptoms per se
- Successive binges are often separate by many days, weeks, or even months, of abstinence or moderate drinking, thereby making it very difficult for the drinker to feel that alcohol is a serious problem or "addiction"
- "Why can't I just stop the binging and drink like I otherwise do?"
- Do I really have to stop drinking completely and forever?

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Alcohol and Other Substances

Identify Combinations
Do you use cocaine, cannabis, prescription drugs, or other substances with alcohol?

Understand Interactions
Combined substances can multiply risks and effects unpredictably.

Recognize Patterns
Notice if certain substances are always used together.

Consider Motivations
Are you seeking enhanced effects or compensating for something?

111

Protective Factors: What Helps You Limit?

Identifying when clients successfully moderate reveals existing strengths and coping strategies to build upon.

- **Accountability structures (plans with others, driving, work next day)**
- **Alternative activities (exercise, hobbies, meaningful engagement)**
- **Supportive relationships (people who don't drink heavily)**
- **Positive emotional states (feeling fulfilled, connected, purposeful)**
- **Physical wellness (good sleep, nutrition, exercise routine)**

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Pros and Cons of Changing

Benefits of Change	Costs of Change
Better health	Social awkwardness
Mental clarity	Finding new coping skills
Better relationships	Changing routines
More money	Facing problems directly
Self-respect	Missing certain experiences

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Significant Others

- Spouse/partner's view of your drinking?
- Nagging, pleading, threatening you to change?
- Major complaints about your drinking?
- Taken any action thus far?
- Supports your efforts to get professional help?
- Wants you to stop drinking completely?
- Would support your effort to cut back substantially?
- Would be willing to join us for an "orientation"session?

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Alcohol Withdrawal

- Alcohol withdrawal symptoms and need for medical evaluation/detox
- Most recent medical exam, blood tests, liver enzymes ever elevated, ever had atrial fibrillation (A-Fib)?
- Prescribed medications- especially Benzos and other sedative-hypnotics due to cross-tolerance and additive dependence

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Assessing Need for Medical Detox

- When was the last time you stopped drinking for at least 3 or 4 days in a row?
- How did you feel during those days?
- Any severe anxiety, agitation, restlessness, insomnia, tremors?
- Have you ever needed medication in the past to help you stop drinking?
- Have you ever in an ER or detox unit for alcohol withdrawal?
- Do you take any tranquilizers, sleeping pills, or sedatives such as Xanax, Klonapin, Ativan, Valium, Zolpidem (Ambien), etc?

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Setting Initial Goals

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Collaborative Goal-Setting

Vague intentions like "drink less" lack the specificity needed to guide behavior change. **Effective moderation requires concrete, measurable goals collaboratively defined with the client.**

Critical principle: Only the client has final say regarding which goals to pursue, regardless of your clinical opinion. Simultaneously, only you determine whether you're willing to support that particular goal.

This mutual autonomy creates honest dialogue where both parties maintain integrity while working toward shared understanding.

Goal specificity matters: "I'll cut back on drinking" becomes "I'll have no more than 2 drinks on Friday and Saturday evenings, and won't drink Sunday through Thursday."

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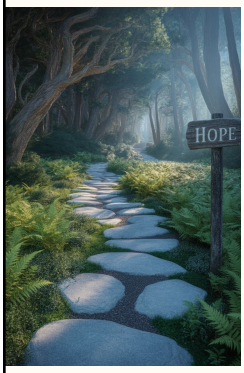

Abstinence or Moderation?

Start where the patient is

Goals must be patient-driven, not diagnosis or clinician-driven

Total abstinence is safest

But only the client can choose their path

Consider an "experiment" with Abstinence

Many open to trial period of abstinence

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Categories of Drinking Goals

Safer Drinking
Reducing risk without necessarily reducing amounts. Example: Never driving after drinking, avoiding drinking when emotionally upset, not mixing alcohol with medications.

Reduced Drinking
Decreasing both amount and frequency. Example: Reducing from daily drinking to 3-4 days per week, cutting number of drinks per occasion by half.

Moderate Drinking
Staying within NIAAA low-risk guidelines: Men: ≤4 drinks/day and ≤14/week. Women: ≤3 drinks/day and ≤7/week.

Tapering ("Warm Turkey")
Stepwise reduction toward eventual abstinence. Allows physiological and psychological adjustment to decreasing amounts.

Abstinence
Complete cessation of alcohol consumption, either temporary or indefinite.

Situational Abstinence
Avoiding alcohol in high-risk situations while drinking moderately in lower-risk contexts. Example: Never drinking at work events, abstaining during stressful periods.

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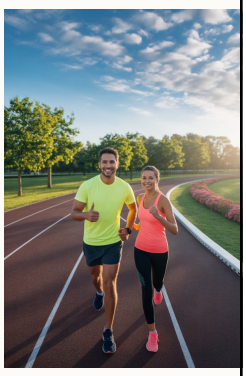
Some Suggested Starting Points

For patients not requiring medical detox

1. **Experiment with abstinence**
   30-90 days; be willing to compromise
2. **Cut drinking by 50%+**
   Reduce volume and frequency
3. **Follow NIAAA "Low Risk" guidelines**
   2-3 drinks, 3-4 days/week, not consecutive



122

When Abstinence is Clearly The Best Choice

Pregnancy
Women who are pregnant or might become pregnant. No level of alcohol is safe during pregnancy.

Medical Conditions
Individuals with conditions that could worsen with drinking, even in moderation.

Loss of Control
People who become aggressive or violent when they drink.

Drinking & Driving
People who drive while intoxicated, especially with history of accidents or DUI/DWI arrests.

Long-Term Abstinence
People already abstinent for a year or longer due to previous serious problems.

123

The Abstinence "Experiment"

This may seem counterintuitive: **One of the most effective paths to successful moderation begins with a period of complete abstinence**. When framed properly, this suggestion meets surprisingly little resistance.

Critical Framing

"I'm not suggesting abstinence because I think you're an alcoholic incapable of moderation. I'm suggesting a temporary break from drinking—an experiment—because it puts you in the best position to succeed with moderation afterward."

The duration varies by individual but typically ranges from 2 weeks to 2-3 months. This isn't about proving anything—it's about gathering information and resetting patterns.

124

Proposing a temporary break from drinking for 30 days or longer

- Convey with an attitude of optimism, hope, and curiosity
- Extremely valuable data-gathering exploration and learning experience
- Not suggesting this because I think you're an alcoholic and must give up alcohol forever
- After explaining the rationale and potential benefits the overwhelming majority of patients agree to do it- surprisingly few refuse!

125

Interrupting the Autopilot Drinking Pattern

Many clients drink automatically: the nightly glass of wine when cooking, the drink after putting kids to bed. A brief abstinence period forces the habit loop into conscious awareness.

Clients often discover that much of their use was driven by environmental cues, time-of-day patterns, or learned associations rather than true preference or need.

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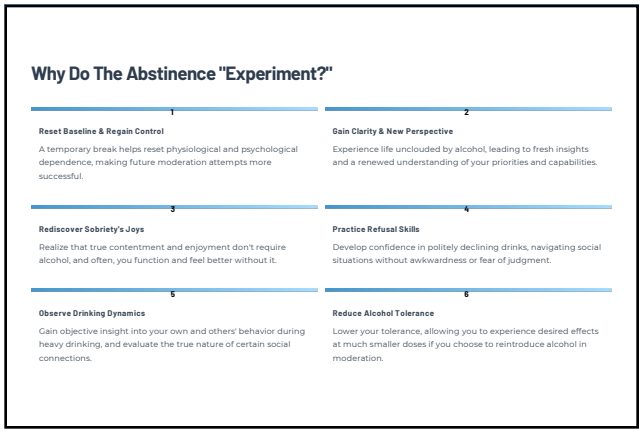

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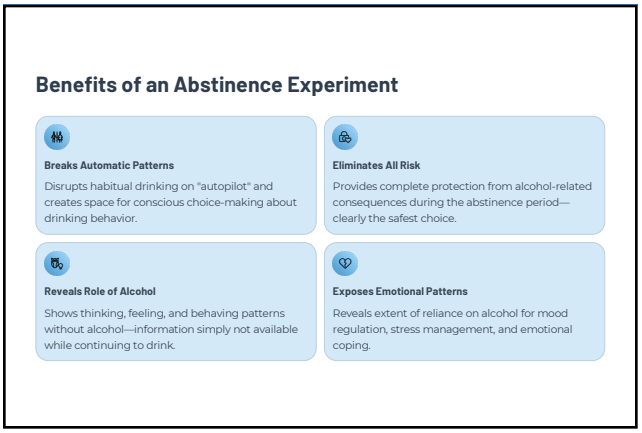

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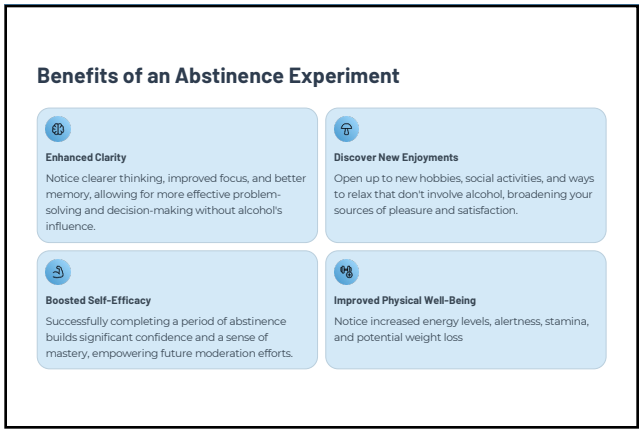

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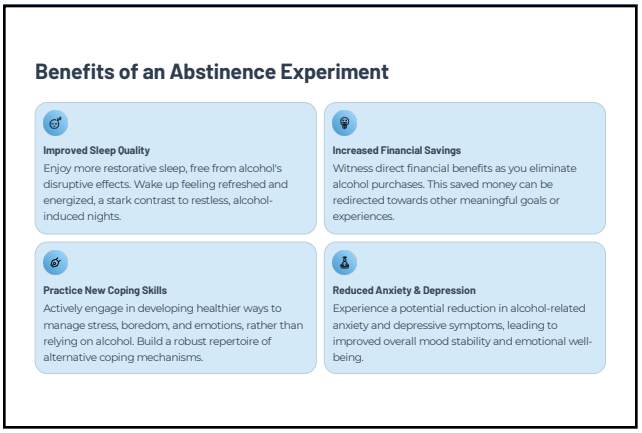

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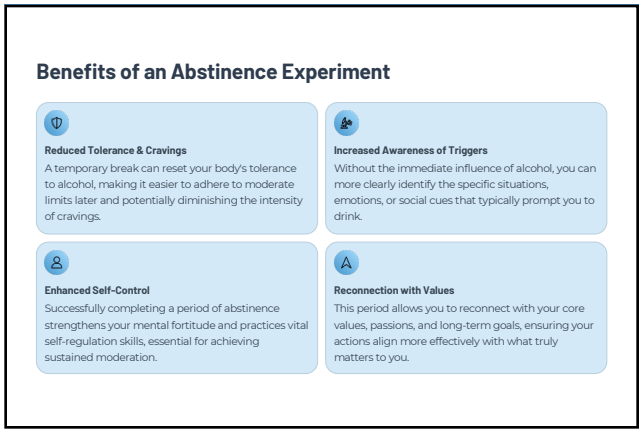

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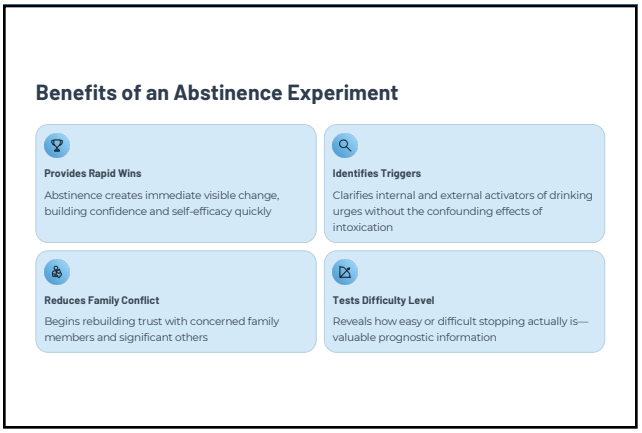

132

Benefits of an Abstinence Experiment

Exposes Unmet Needs
Reveals voids in life being masked or medicated by drinking

Enhances Medication Effectiveness
Allows psychiatric medications for depression, anxiety to work optimally without alcohol interference

Creates Emotional Access
Provides opportunity to experience and learn healthier ways of managing emotions

Gives Your Brain A Chance to "Reset"
Allows time for some of the biochemical impact of alcohol on your brain to dissipate

133

Surprisingly Good Acceptance of a Proposed "Experiment" with Abstinence

- When abstinence is presented as part of a learning endeavor—not the beginning of abstinence forever—patients often see it as a sensible first step and find it to be much easier than expected.
- "Knowing that maybe I can drink again, stopping for a while doesn't feel like a defeat or having to see it as an irreversible problem ("disease")
- "Also, I don't feel any great pressure to prove right now that I can drink moderately."

134

Initiating Abstinence: Quitting Strategies

- Choose a specific date to stop drinking completely for at least 30 days (shorter, if needed)- assuming no withdrawal risk
- Identify potential obstacles and facilitators
  - Identify upcoming "high risk situations", "windows of opportunity" and other drinking activators
  - Enlist social support from partner, family, friends
  - Plan activities and schedules to avoid boredom and unstructured time
  - Keep a journal of thoughts, moods, cravings

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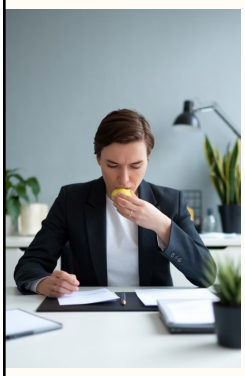

Craving Management Techniques

1. **Think Beyond the High**
   Counter euphoric recall, remember consequences
2. **Leave the Situation**
   Change environment, find alternative activities
3. **Use Thought Stopping**
   Change visual cues, focus attention outward
4. **Reach Out for Help**
   Contact support person when cravings start

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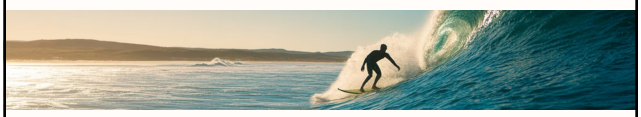

How Urge Surfing Works

Observe the Urge
Like a curious scientist, notice the craving's thoughts, feelings, and physical sensations without judgment. Simply acknowledge its presence.

Allow it to Pass
Ride the "wave" of the craving, knowing it will peak and then naturally subside. Continue observing without acting on the urge until it diminishes completely.

Accept its Presence
Don't fight or try to suppress the urge. Understand that it's a temporary mental and physical sensation, not a command you must follow.

Focus on Sensations
Direct your attention to where you feel the urge in your body. Notice its intensity, warmth, pressure, or tingling, and how these sensations change.

137

Drink Refusal Skills

Having prepared responses prevents being caught off guard when offered drinks:

"I decided to stop drinking for a while."

"I'm not interested in drinking tonight."

"I'm driving tonight, so I'm not drinking."

"I took a break from drinking and love how I feel now."

Remember: A simple "I'm drinking seltzer tonight" is enough. No explanation required.

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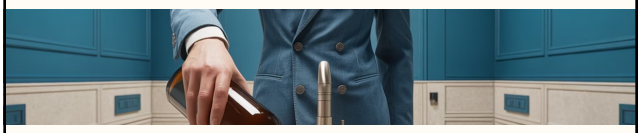

Abstinence-Supportive Strategies

01
Remove Alcohol from Home
Eliminate temptation by clearing out all alcoholic beverages.

02
Develop New Routines
Replace drinking rituals with healthy alternatives and new habits.

03
Build Sober Support Network
Connect with others in recovery through AA, SMART Recovery, or therapy groups.

04
Practice Refusal Skills
Rehearse how to decline drinks confidently in social situations.

139

Maintaining Your Social Life Without Drinking

Being sober doesn't mean giving up your social connections. With the right strategies, you can navigate social situations confidently and enjoy meaningful relationships without alcohol.

140

Learning from Slips

Definition
Brief episode falling short of full return to former drinking pattern

Therapeutic Approach
Address non-judgmentally, reframe as avoidable but informative

Analysis
Review scenario and circumstances to prevent recurrence.

Common Trigger
Often preceded by boredom, stress, desire to "test control".

141

Navigating Early Slips: Therapeutic Approaches

- Slips are common and should be viewed as learning opportunities.
- Therapists can help clients reframe these experiences, identify triggers, and strengthen coping strategies.
- It's crucial to maintain a non-judgmental stance and reinforce the client's commitment to change.

142

Results of the Abstinence "Experiment"

Most complete at least 30 days with relatively little or no difficulty (typically those with lower-severity problems).

- Either stay completely abstinent or have 1 or 2 brief, usually non-intensive drinking episodes
- Many choose, much to their own surprise, not drink on the day after completing the experiment, but rather to extend it for a while longer (open-ended based on what transpires)
- Fewer choose to immediately begin a trial of moderate drinking
- They often remark that it was easier, more informative, and felt better than expected
- Feel empowered knowing they can choose not drink, exert the needed self-control to follow through on that decision, and see that they actually can have fun and socialize without alcohol

143

Results of the Abstinence "Experiment"

- Others experience considerable difficulty in completing the experiment, especially those with a long history of intensive episodic binge drinking or prior physical dependence on alcohol requiring medical detox
- With therapeutic support and encouragement, many come to realize that continuing to drink at any level is simply not feasible for now and switch their goal to open-ended abstinence, usually with a sense of relief and appreciation for the opportunity to find this out for themselves without pressure or judgment.

144

Results of the Abstinence "Experiment"

- Still others who start the abstinence experiment, choose not to complete it, drink within reasonable limits on a number of occasions, and request ongoing help with continuing on that course
- A relatively small number (fewer than 10%) precipitously drop out of treatment during this initial period and are lost to follow up

145

Not Ready or Willing to Take a Break from Drinking?

- Suggest a series of "mini" breaks (a few days or a week at a time)
- Suggest a tapering schedule to reduce amount/frequency of drinking (e.g., by at least 50%)
- Encourage mindfulness about how it feels on drinking vs. non-drinking days/weeks
- Acknowledge/reinforce any positive steps including increased mindfulness about drinking even if alcohol consumption remains unchanged

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Non-Abstinence Goals

- **Moderate Drinking**: at levels within established guidelines (e.g., NIAAA)
- **Managed/Controlled Drinking**: at levels that avoid harmful consequences
- **Less Risky/Less Harmful Drinking**: at levels that reduce the likelihood but do not totally avoid/prevent harmful consequences

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Moderation Strategies

- Work collaboratively to formulate a specific drinking plan
  - Amount/frequency limits
  - Types of beverages
  - Where, when, with whom?
  - How to respond to drinking beyond the specified limits
- Keeping a log of alcohol consumption
- Caution the patient that after a period of abstinence alcohol tolerance diminishes and smaller amounts of alcohol will have greater effects

148

"IDEAL" Drinking Plan

- An exercise to help identify problematic and non-problematic aspects of alcohol use
- What would a "healthier" or more acceptable relationship with alcohol look like for you?
- What pattern/level of drinking would provide you the most benefit with the least risk?

149

Self-Control Strategies

- Drink MINDFULLY, not MINDLESSLY
- Remain vigilantly aware in real time of your state of intoxication/mood alteration as you continue to drink SLOWLY (no more than 2 drinks in an hour)
- Stop drinking before you stop thinking and lose your "off switch"

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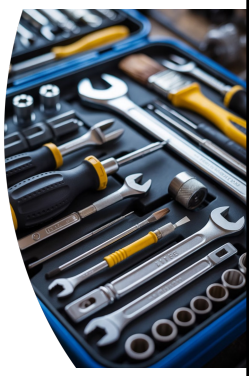
Behavioral Self-Control "Toolkit"



Successful moderation requires mastering specific cognitive and behavioral techniques. **These evidence-based strategies help clients exert better control over their drinking behavior**.

The following techniques should be provided as a handout clients can reference. Consider framing these as a "toolkit" where clients experiment to discover which strategies work best for them.

Teaching approach: Don't simply hand clients a list. Discuss each strategy, explore potential obstacles to implementation, and problem-solve how to apply techniques in their specific situations.

151

HANDOUT: 10 Drinking Control Strategies

1. Keep track of your alcohol intake in real time
2. Switch to lower proof beverages
3. Include food and non-alcoholic beverages
4. Pace and space (especially during the first hour)
5. Don't drink on consecutive days
6. Don't drink with heavy drinkers
7. Don't drink alone or when emotionally upset
8. Don't drink past your "off" switch
9. Stop drinking before you stop thinking
10. Think about tomorrow

152

Self-Control Techniques: Beverage Choices

Don't Drink for the Buzz

If you're already "buzzed," **your drinking off-switch is disabled**. Intentions dissolve in alcohol. Urges to overdrink activate. Pace, space, and mindfulness prevent reaching this point.

Switch to Lower Proof

Lower alcohol-by-volume means slower intoxication. **Consider beer or wine instead of distilled spirits**—but don't compensate by drinking much more.

Don't Keep Alcohol at Home

Immediate availability increases temptation and makes resistance harder. Drinking at home reinforces home-drinking connection, making the cycle harder to break. Home should be refuge from drinking, not a trigger encouraging it.

153

Self-Control Techniques: Social Strategies

Avoid Drinking Alone

Temptation and opportunity to overdrink increase when alone. Social interactions and constraints on drinking are absent. **Solitary drinking often involves different motivations—usually coping with negative emotions.**

Careful with Heavy Drinkers

Others' drinking patterns influence your own. **If you must be around heavy drinkers, have club soda with lime to deflect attention** and skip rounds without awkwardness.

Prepare Refusal Skills

Decide in advance what you'll say when offered too many drinks. Simple options: "No thanks, I've had enough." "I'm trying to improve my fitness." "Too much disrupts my sleep." "I'm taking it easy tonight."

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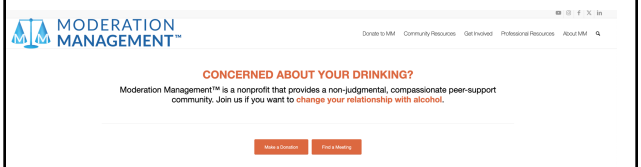
Mutual-Help Groups and Other Resources Supporting Moderation

www.moderation.org



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When Moderation Doesn't Work: Making the Shift

When clients repeatedly struggle with moderation despite professional support, **it's time to encourage a trial with abstinence**. This shift requires careful therapeutic framing.

Critical reframe: "Your attempt at moderation hasn't failed—it's provided valuable information. You've learned that controlling your drinking requires more effort than you want to invest. That's important data that helps us chart a better course forward."

Many clients who don't succeed with moderation become more motivated to try abstinence after experiencing firsthand the difficulty of maintaining control.

156

Therapeutic Responses to Moderation Struggles

01
Acknowledge the Effort
"You've given moderation a genuine try. That took courage and commitment."

02
Normalize the Experience
"Many people discover that moderation is harder than expected. This is common and doesn't reflect weakness."

03
Highlight Learning
"What have you learned about your relationship with alcohol? About your triggers? Your coping patterns?"

04
Introduce Abstinence Gently
"Some people find that abstinence is actually easier than the constant effort moderation requires. Would you be open to exploring that option?"

05
Support the Transition
"Let's talk about what abstinence would look like for you, what supports you'd need, and how we'd work toward that goal together."

157

Non-Alcoholic Drinks in Recovery: Help or Hindrance?

158

Potential Benefits

Social Inclusion
Helps maintain social engagement without isolation

Mindful Drinking
Promotes awareness and control of consumption habits

Psychological Relief
May reduce cravings by mimicking ritual without alcohol

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Potential Risks

1
Psychological Triggers
Taste and smell can evoke cravings

2
Reinforced Habits
May maintain attachment to drinking rituals

3
Slippery Slope
Could rationalize "just one real drink"

160

Cannabis and Alcohol Moderation: Help or Hindrance?

When seeking to reduce alcohol consumption, some turn to cannabis as an alternative. But does this substitution help achieve moderation goals or create new problems?

161

Cannabis as a Substitute for Alcohol: Promising Evidence

Clinical Research
Study of 96 heavy drinkers in treatment showed 29% fewer drinks and 2+ less binge drinking on cannabis-use days (Karoly et al., 2021)

Population Trends
Medical cannabis users report using cannabis specifically to reduce alcohol intake; states with lenient cannabis laws see measurable decreases in overall alcohol consumption

Strain Differences
CBD-dominant cannabis linked to fewer drinking days and less co-use compared to THC-heavy strains (University of Colorado study)

162

Risks and Challenges of Cannabis Use in Alcohol Moderation

Some research finds heavy drinking more likely on marijuana-use days, especially in those with alcohol use disorder (Metrik et al., 2018)

Simultaneous use of alcohol and cannabis can increase risk of impaired driving, cognitive decline, and dependence on both substances

Cannabis substitution may not reduce harms for all; some studies show worse drinking outcomes or less abstinence among cannabis users in alcohol treatment

163

Medications That May Help with Moderation or Abstinence

164

Role of Medications

Reduce Craving	Support Abstinence	Prevent Relapse
Make it easier to cut down or stop by decreasing urges and reward	Reinforce time-limited abstinence by decreasing urges and building self-efficacy	Blunt reinforcing effects after a slip to prevent full relapse

165

Adjunctive Medications

Pharmacotherapy can enhance psychotherapy outcomes, particularly for reducing cravings and supporting moderation or abstinence goals.

Naltrexone
Blocks opioid receptors, reducing the rewarding effects of alcohol and decreasing cravings.

Disulfiram (Antabuse)
Creates unpleasant reaction if alcohol is consumed, serving as a deterrent to drinking.

GLP-1 Agonists
Emerging evidence suggests medications like semaglutide may reduce alcohol consumption and cravings.

Medication should be prescribed and monitored by a physician, ideally in coordination with psychotherapy.

166

Psychologist's Role in Pharmacotherapy

What Psychologists Can Do:

- Screen for appropriateness (severity, goals, medical risk)
- Discuss pros/cons in simple language
- Coordinate care with prescribers
- Monitor behavioral effects

Medications do not replace psychotherapy—they extend the client's capacity to implement behavior change strategies developed in session.

167

Naltrexone (ReVia, Vivitrol)

- In my clinical experience to date, neither naltrexone or acamprosate are very effective in reducing alcohol cravings or consumption levels
- Only about 10-15% of my clients (and those of other colleagues) who have tried these medications have reported positive benefits and most discontinue taking it after a few weeks or less

168

Antabuse (disulfiram) can be extremely helpful!

- Helps to "jump start" abstinence
- Prevents impulsive (unplanned) drinking
- Imposes 3-5 day delay before taking a drink without activating the alcohol-Antabuse reaction (nausea, vomiting, headache, restlessness, etc.)
- Must be at least 24 hours alcohol free before starting or re-starting Antabuse

169

Antabuse (Disulfiram) can be extremely helpful!

- Taken daily first thing in morning when the desire to drink is minimal or absent
- Alternatively, can be taken situationally as needed to support abstinence in anticipation of exposure to "high risk" drinking situations
- Reliably eliminates cravings/obsession as a result of knowing that drinking is not an available option
- Well tolerated. Adverse side effects are very rare

170

Antabuse (Disulfiram) can be extremely helpful!

- Unfortunately, except for addiction specialists, most physicians are not familiar with prescribing Antabuse and are therefore hesitant to do so
- Despite it having been approved by the FDA since 1951 for the treatment of alcohol dependence, Antabuse is grossly underutilized in part because it was long ago dismissed in the AA community as a "crutch" that interferes with attaining "true" recovery

171

GLP-1 Agonists: Emerging Evidence

GLP-1 agonists (e.g., Ozempic, Mounjaro) show promise in reducing alcohol consumption.

Preliminary Findings

Patients report reduced cravings and consumption, likely via reward pathway effects.

Current Status

Not FDA-approved for AUD. Research is ongoing, with emerging off-label use.

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GLP-1 Agonists (off-label, not FDA-approved)

- Semaglutide (Ozempic, Wegovy)
- Tirzepetide (Mounjaro, Zepbound)
- Results of preliminary trials are very encouraging- controlled studies are still underway
- To date, approximately 25 of my patients have tried these medications with excellent results in terms of reduced alcohol cravings and improved ability to sustain moderation or abstinence
- Tirzepetide appears to be more effective than semaglutide and has fewer side effects (e.g., GI distress)

173

Case Vignettes: Multiple Pathways to Incremental Change

These case vignettes illustrate different pathways of incremental change from problematic alcohol use to sustained moderation or abstinence. Change is rarely linear and often involves personalized approaches that acknowledge individual circumstances and goals.

174

Structure & Format of My Clinical Practice

- Private, addiction psychology practice conducted exclusively online
- Patient population
  - Functional employed adults, ages 25 to 75
  - Adolescents/young adults and their parents are treated separately– by Lori Washton, Ph.D.
- Treatment options
  - Individual and/or group therapy
  - Patients already in outside individual therapy can participate in groups while continuing with their therapist
  - Short-term supportive couples/family counseling (referred out for ongoing couples therapy, as needed)

175

Structure & Format of My Clinical Practice

- All patients start with an Initial Assessment followed by at least 2 or 3 Individual Sessions
- Some patients then join a Group and either continue individual sessions with me or their outside therapist
- Others do not join a group (for practical and/or clinical reasons) and receive individual treatment alone– while continuing with their outside individual therapy, as indicated
- Each group cohort meets once per week online (Zoom), 8-10 members, both men and women, ages 25-75, include both moderators and abstainers, open-ended, duration of group participation ranges from weeks, to months, to years, rolling admission- new members join as others leave

176

Structure & Format of My Clinical Practice

- Patients can participate in more than one group per week, as needed
- Medication, when indicated, is provided by collaborating addiction psychiatrists

177

Five Unique Journeys

Nila
Brief abstinence → stable moderation

Doreen
Abstinence → moderation transition

Paul
Multiple moderation attempts → stable abstinence

Cedrick
One year abstinence → 3+ years stable moderation

Victor
Requested moderation but eventually opted for abstinence

178

Meet "Nila"

36-year-old journalist and digital marketing strategist. Marathon runner with active fitness lifestyle.

The Struggle
Five years of alcohol blackouts

The Trigger
Relationship end + father's health decline

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Nila's Journey to Treatment

Treatment History

Two years of psychotherapy with limited progress

The Escalating Pattern

- Multiple unsuccessful attempts to moderate or quit
- Overdrinking frequency increased significantly
- Two blackouts in past week
- Sexual encounter with stranger during blackout

This incident became a powerful catalyst for seeking specialized addiction treatment.

180

Nila's Initial Presentation

> "I'm here because I don't want to quit drinking forever. My goal is to better manage my drinking and avoid blackouts. I know there's emotional stuff I need to address, but not until my drinking is under control."

Nila's statement revealed a common pattern: the desire to control, rather than eliminate, alcohol. Her ambivalence—wanting change but not wanting to change too much—became central to our therapeutic work.

181

Initial Treatment Planning

1	2	3
Explore Options	**Try an Experiment**	**Reduce Resistance**
Compare moderation and abstinence approaches.	Frame abstinence as a time-limited trial.	Address ambivalence and practical barriers.

We explored moderation versus abstinence—what worked best for Nila's specific circumstances, patterns, and goals.

Nila's recent traumatic episode created an opening for change. To support this, I presented abstinence as an "experiment"—temporary, informative, and without permanent commitment.

182

Establishing the Treatment Framework

Treatment Structure
Weekly individual sessions for 12 weeks

Group Participation
Nila declined weekly support group; option kept open

Initial Focus
Identified high-risk situations and drinking triggers

183

Understanding Nila's Drinking Patterns

Social Drinking
Friday evenings at restaurant/bar with coworkers—highest risk for overdrinking

Isolation Pattern
New pattern: drinking alone at home with wine purchased after work

Early Setbacks
Three weeks avoiding high-risk situations increased isolation and depression, leading to heavy drinking on two consecutive weekends

184

Developing Self-Control Strategies

Practical Strategies

Nila began implementing drinking self-control: pacing, delaying, diluting, alternating drinks.

Uncovering Emotional Drivers

Identified emotional drivers: unresolved grief from past relationship and anticipatory loss from father's declining health.

Profound Revelation

Nila disclosed terminating a pregnancy—an unmourned loss that profoundly compounded her grief. Alcohol temporarily dulled these unaddressed emotions rather than allowing therapeutic processing.

185

Building Support and Refining Goals

1. **Enlisting Social Support**
   Nila enlisted friends' support, asking them not to encourage overdrinking
2. **Collaborative Care**
   Regular contact with therapist ensured coordinated care. Two paths: reduce drinking to monthly or complete 30-day break
3. **Progress and Challenges**
   Reduced drinking amount and frequency. Still, two severe intoxication incidents occurred, triggered by relationship issues

186

Nila's Path to Recovery

Nila opted for reduced frequency, limiting drinking to controlled circumstances with a "safe" friend who supported moderate drinking.

1. **Initial Moderation**
   Identified safe friend for support
2. **Consistent Months**
   Nine months of moderate drinking
3. **Reduced Compulsion**
   Craving diminished significantly
4. **Gradual Ending**
   Contact decreased to monthly, then bimonthly

Five years later: mostly abstinent, drinking moderately on occasion with no heavy episodes. Married to a man in long-term recovery, raising two young children.

187

Meet "Peter"

Personal Background
45-year-old corporate manager, married with two teenage children. Stable professional life and strong family relationships.

Drinking History
Started in college with fraternity binge drinking. No daily drinking, physical dependence, or serious incidents like DUIs.

Growing Concerns
Wife grew concerned about drinking patterns, eventually motivating him to seek help.

188

Peter's Initial Presentation

> "I'm here at the suggestion of the psychologist I've been seeing for help with anxiety—a problem I've suffered with for my entire life. I'm extremely self-conscious, constantly worried about what other people think of me."

Previous Treatment Failures

- Various SSRIs (like Prozac)
- Nearly a year of CBT
- No significant success

The Critical Factor

Peter had not disclosed his drinking to either professional until two weeks before this meeting. His therapist's immediate referral marked a crucial turning point.

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Peter's Relationship with Alcohol

> "The only thing that relieves my anxiety is alcohol. I drink late in the evening when my wife and kids are asleep and in just about every social situation."

The Turning Point
During a Sunday football gathering, Peter drank so heavily he passed out before guests arrived, missing the entire event. His wife and parents were upset, and Peter felt deeply humiliated.

His Request
"I know I've got to do something about my drinking, but I absolutely do not want to give it up forever. I want to learn how to moderate my drinking. Can you help me with that?"

190

Peter's Treatment Journey

1

Two-Week Abstinence "Experiment"
Peter reluctantly agreed to a two-week abstinence "experiment." He deeply worried that not drinking would harm his social life and business relationships.

2

Extended Experiment for Two More Weeks
Encouraged by completing the first two weeks, he extended the experiment for another two weeks, on condition that a moderation plan would begin in Week 5.

3

Joined Weekly Support Group
Peter also joined a weekly support group—transformative for peer support, accountability, and normalization of his struggles.

191

Peter's Path to Sustained Recovery

01

Months 1-4: The Exploration Phase
Peter alternated 4-5 cycles of moderation and abstinence. Chronic anxiety subsided with reduced alcohol. Psychiatrist prescribed lorazepam for breakthrough anxiety.

02

Month 4: The Turning Point
After four months in the group, Peter chose complete abstinence. This decision stemmed from growing awareness, not external pressure.

03

Years 1-4: Sustained Sobriety
Peter maintained continuous sobriety for four years, continuing weekly individual and group therapy.

04

Ongoing Work: Deeper Issues Emerge
Addressed chronic anger towards wife, emotional dependence on parents, lifelong self-esteem deficits, and parenting challenges.

192

Meet "Dayna"

55-year-old businesswoman referred by couples therapist.

1

Nightly Glasses: 2-3

Consistent weeknight pattern

2

Weekend Glasses: 5-8

Escalating weekend consumption

3

Days in Rehab: 28

Two years earlier, under family pressure

She found the inpatient experience unhelpful and "absolutely hated" it, significantly impacting her future receptiveness to treatment.

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Dayna's Initial Presentation

"I know that I drink too much, but I'm not an alcoholic. Going away to rehab again is absolutely out of the question. I don't want to give up drinking. I want to moderate and make sure I don't overdo it."

The Catalyst

Dayna sought treatment under renewed family pressure following a dangerous incident: she drove home drunk from dinner. Her family insisted she return to inpatient rehabilitation—a prospect she firmly rejected.

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Establishing a Treatment Alliance

Balancing Honesty and Hope

I clearly expressed concerns about Dayna's severe drinking, emphasizing the dangers of drunk driving. This wasn't judgment, but clinical reality.

I also offered to help her change her relationship with alcohol through a collaborative plan.

The Abstinence Experiment

I proposed a temporary 30-day abstinence "experiment."

- Reduced family pressure
- Clarity on alcohol relationship
- Foundation for moderate drinking plan

This wasn't permanent abstinence or acceptance of the "alcoholic" label—it was a strategic, time-limited experiment.

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Building the Foundation for Change

Dayna agreed to stop drinking immediately for 30 days—a significant commitment given her previous resistance.

Trigger Identification

Mapped drinking triggers and developed management strategies

Time Planning

Structured evenings and weekends with alternative activities

Support System

Identified support and accountability sources beyond family

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Navigating Family Dynamics

1

Concerns

Husband voices worry about moderation

2

Validation

Therapist acknowledges fears and anxiety

3

Agreement

Support 30-day plan with review

At our next meeting, Dayna's husband expressed strong disagreement with my moderate drinking philosophy. His concerns were understandable: all previous moderation attempts had failed.

I empathized with his fears, validating his concerns stemmed from love and legitimate worry. I emphasized the next 30 days would provide valuable information for everyone.

Dayna joined a weekly support group and not only completed the initial 30-day abstinence but extended it to 90 days before beginning work on a moderate drinking plan.

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Dayna's Ongoing Recovery

Deeper Therapeutic Work

Weekly individual therapy addressed conflicted feelings about her 30-year marriage and hostile dependency on her husband.

Processing Loss and Transition

Addressed the empty nest transition: both daughters moved away for graduate school and careers, triggering grief and vulnerability.

Moderation Success

Maintained moderation for over two years, with only two heavy drinking episodes (no DUIs). This success transformed family dynamics.

Her husband is now satisfied with her progress, humorously admitting he no longer finds the approach "nuts." Dayna's case demonstrates moderation can succeed when underlying emotional issues are addressed with strong support.

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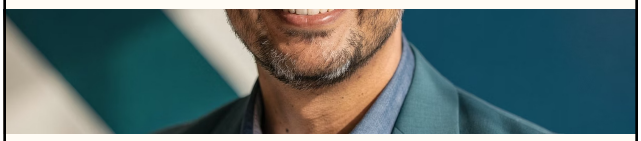

Meet "Cedrick"

Demographics
34-year-old real estate broker, married with no children

Drinking History
College binge drinking and marijuana use, recent return to binge drinking with partial blackouts

Crisis Point
Sexual encounter with former girlfriend during college reunion drinking binge, confessed to wife one week before seeking treatment

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Cedrick's Initial Presentation

> "I was strongly encouraged to see you by a close friend who has been doing really well since joining one of your groups, although his alcohol problem is far more serious than mine. However, I am definitely at risk of losing my marriage if I don't get my drinking under control and stop doing crazy things when I get blackout drunk."

Unlike his friend, Cedrick didn't drink daily, had never been physically addicted, and wasn't at risk of losing his job. But his blackout drinking posed a severe threat to his marriage—his highest priority.

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Beginning Cedrick's Recovery Journey

Cedrick agreed to a 30-day "experiment with abstinence." Unlike others, he embraced this commitment willingly and enthusiastically.

His clear motivation: to prove to his wife—and himself—his seriousness about changing his behavior.

He immediately joined a weekly support group, finding peers who shared similar experiences with alcohol-fueled decisions. The group provided validation, reduced shame, and offered practical strategies.

201

Navigating Early Sobriety Challenges

1

Social Adjustments

Cedrick struggled with necessary social changes. He avoided drinking buddies and work dinners involving heavy drinking, leading to social isolation that tested his commitment.

This common early recovery challenge involves recognizing that some relationships and activities are temporarily incompatible with sobriety.

2

Uncovering Marital Dissatisfaction

In individual therapy, Cedrick revealed profound marital unhappiness predating his infidelity. He cited his wife's negative moods, lack of sexual intimacy, and distress from failed IVF.

These revelations reframed his drinking and infidelity within a broader context of marital distress—not an excuse, but important for understanding his vulnerability.

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Cedrick's Evolving Recovery Path

Year 1: Complete Abstinence
Maintained complete abstinence, focusing on healing and addressing underlying issues

Careful Moderation Plan
After one year: 2-3 drinks per occasion, 2-3 times per week, avoiding high-risk situations

Cannabis as Alternative
Occasionally used non-alcoholic beers and cannabis products (edibles, vapes) in moderation

5+ Years: "Pretty Good" Moderation
Largely adhered to plan. Occasional excessive drinking addressed by 1-2 months abstinence before resuming

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Meet "Victor"

54-year-old anesthesiologist, married to an internist with three adult children. His case highlights unique challenges healthcare professionals face with alcohol problems.

Unlike other cases, Victor had no prior history of substance use. His drinking began during his demanding anesthesia residency—a period marked by grueling marathon shifts.

Initially, his drinking was a way to decompress after intense shifts at social gatherings. This pattern seemed manageable for years, even normal within a medical culture where alcohol is an implicitly accepted form of stress relief.

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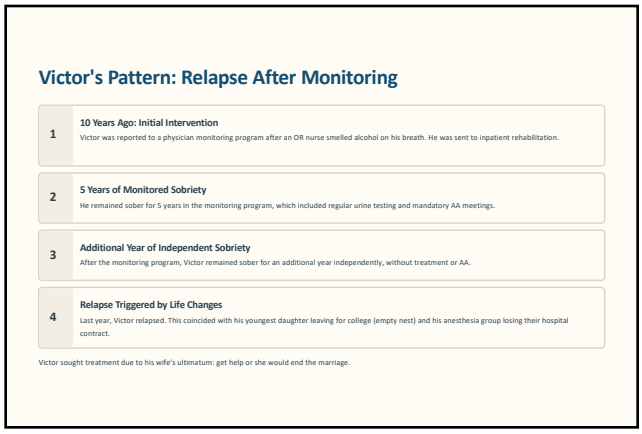

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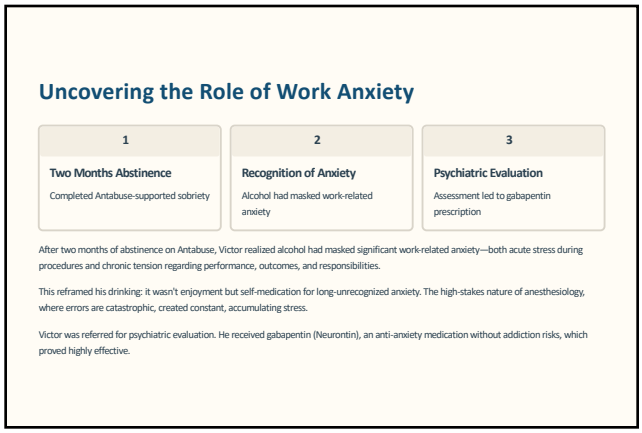

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