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Treatment Approaches to Alcohol Problems

This book is intended for clinicians wishing to use a self-management approach in the treatment of persons who have nonsevere alcohol problems. The approach is largely motivational and cognitive-behavioral. It is directed toward helping people help themselves. While the nature of the target population—persons whose alcohol problems are not severe, whom we will define as "problem drinkers"—is discussed at length in this book, an understanding of this treatment approach is enhanced by viewing the alcohol field in perspective. Self-management approaches have been a part of an evolution of treatment approaches within the alcohol field. In a broader context, this evolution is consistent with changes occurring in other health-related fields, where there has been a growing acceptance of brief treatments and self-help based interventions for many health and mental health problems (Mahalik & Kivlighan, 1988; Scogin, Bynum, Stephens, & Calhoon, 1990). For this book, however, consideration of these issues will be restricted to the alcohol field.

The Evolution of Approaches to the Treatment of Alcohol Problems

It is now widely acknowledged that treatment for alcohol problems has developed in and continues to be practiced in the relative absence of integration of scientific knowledge about the nature of the disorder (Gordis, 1987; Heather & Robertson, 1983; Pattison, Sobell, & Sobell, 1977). One reason for this state of affairs is that treatments for alcohol problems were not initially based on scientifically derived knowledge about the disorder but rather on anecdotal and subjective impressions. Another reason is that although considerable scientific knowledge about alcohol problems has accumulated over the past 30 to 40 years, the treatments most widely available in North America are

remarkably similar to those used several decades ago (Cook, 1988a, 1988b; Fingarette, 1988; Hill, 1985; Peele, 1990). These treatments either lack research support or are contraindicated by research evidence (Fingarette, 1988; Hill, 1985; Miller & Hester, 1986a; Peele, 1989; Shaffer, 1985).

In what follows, we will call "belief based" those treatments that have been developed without a research basis. Most often these are 12-step treatments based on the Alcoholics Anonymous literature (Nowinski, Baker, & Carroll, 1992). Treatments that have been empirically evaluated and have a scientific basis will be referred to as research based.

In light of how the alcohol treatment field has evolved, an interesting question is why treatments should be research based. If one considers treatments for other health problems, the answer, reflected in the words of Enoch Gordis, a physician and director of the National Institute on Alcohol Abuse and Alcoholism, is obvious:

> It would be unthinkable, for instance, to unleash a new drug therapy for cancer, a new antibiotic for kidney disease, a new medicine for the prevention of second heart attacks or even a new flavoring agent for foods without careful evaluation and planning. . . . Yet in the case of alcoholism, our whole treatment system, with its innumerable therapies, armies of therapists, large and expensive programs, endless conferences, innovation and public relations activities is founded on hunch, not evidence, and not on science. . . . [T]he history of medicine demonstrates repeatedly that unevaluated treatment, no matter how compassionately administered, is frequently useless and wasteful and sometimes dangerous or harmful. (Gordis, 1987, p. 582)

In spite of Gordis's admonition, the most common treatment programs in the alcohol field, the Minnesota Model programs (Cook, 1988a, 1988b), are 28-day intensive inpatient programs. These and most traditional alcohol treatment programs have not been evaluated in the kinds of controlled trials that would support their widespread acceptance. In addition, there has been no research showing that these approaches are more effective than alternative, less intrusive, and less costly approaches. Much of what is taken for granted about the nature of alcohol problems and its treatment is based on beliefs rather than research. Unfortunately, while research-based treatments can and have changed to accommodate new research findings, belief-based treatments have changed very little despite contradictory evidence.

Some Key Issues

While it is not our purpose in this book to present an in-depth review of conventional notions about alcohol problems and treatment approaches, certain aspects of alcohol problems and treatment are important to the understanding of self-management treatments. One point we wish to emphasize is that conventional treatments were developed to treat *chronic* alcoholics. The program we present in this book is intended for persons who are *problem drinkers* (see Chapter 3).

There is considerable disagreement in the alcohol field about what constitutes alcohol problems and who has them. For example, what are the differences between those labeled as alcoholic and those we call problem drinkers? More specifically, what are the defining features of alcoholism versus heavy drinking? Is alcohol dependence a better term than alcoholism? These and dozens of definitional questions cannot be answered, for there is no consensus on terminology in the alcohol field.

Consideration of some recent definitions will illustrate these difficulties. In the *Seventh Special Report to the U.S. Congress on Alcohol and Health* (National Institute on Alcohol Abuse and Alcoholism, 1990), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) divides the drinker population into three groups: (1) persons who drink with few, if any, problems; (2) nondependent problem drinkers who have difficulties secondary to alcohol consumption; and (3) persons who are dependent on alcohol and who suffer from the disease called alcoholism or alcohol dependence. The latter individuals are characterized by (a) tolerance, (b) physical dependence, (c) impaired control over regulating drinking, and (d) the discomfort of abstinence, or craving. The report goes on to assert that "an estimated 10.5 million U.S. adults exhibit some symptoms of alcoholism or alcohol dependence and an additional 7.2 million abuse alcohol, but do not yet show symptoms of dependence" (National Institute on Alcohol Abuse and Alcoholism, 1990, p. ix). Based on this, the NIAAA defines two types of alcohol problems—alcohol dependence (which is referred to as alcoholism) and alcohol abuse (which is referred to as nondependent problem drinking)—and they assert that the population of dependent persons is approximately 45% larger than that of alcohol abusers. This classification, however, relies upon the difficult-to-define and even more difficult-to-measure characteristic of "impaired control over regulating drinking."

In contrast to the NIAAA estimate, a recent report to the NIAAA by the Institute of Medicine (IOM) of the U.S. National Academy of Sciences states that "Approximately one-fifth [of the population of the United States] consumes substantial amounts of alcohol, and approximately 5 per cent drink heavily" (Institute of Medicine, 1990, pp. 30–31). The IOM report defines the former group as "problem drinkers" and the latter group as "alcoholics" or "dependent drinkers." The findings are summarized as "most people have no alcohol problems, many people have some alcohol problems, and a few people have many alcohol problems" (Institute of Medicine, 1990, p. 214). According to the IOM report, there are four times as many problem drinkers as there are alcohol-dependent individuals.

To complicate matters, consider definitional changes that have occurred in the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association. Whereas the Institute of Medicine report (1990) cites references in support of its classifications, the DSM diagnoses are based on consensus by a panel of professional consultants. The third edition of the manual, revised in the mid-1980s (DSM-III-R; American Psychiatric Association, 1987), includes categories of alcohol abuse and alcohol dependence, with definitions relatively consistent with those used by the Institute of Medicine. However, a fourth edition of the manual, which is intended to serve as the mainstay for psychiatric diagnoses for the 1990s, may change these definitions so that most of what has been considered alcohol abuse in the DSM-III-R will now be considered low-level dependence (Nathan, 1991), thereby blurring the definitional distinction introduced by the IOM (1990) report.

Obviously, there are many classifications and definitions of alcohol problems. However, since this book is intended as a guidebook for practitioners, we will use definitions that have practical value. Thus, when we refer to chronic alcoholics, we mean the stereotypical image of the alcoholic, the image often portrayed in the media. Chronic alcoholics are individuals whose life is centered around procuring and consuming alcohol and who, upon stopping drinking, suffer severe withdrawal symptoms (e.g., severe tremors, hallucinations, seizures, delirium tremens). Some chronic alcoholics will experience significant brain and other end organ damage (e.g., cirrhosis) as a result of their drinking. Usually there is extensive social impairment, for example, few meaningful relationships with family members, vocational problems, and a history of alcohol-related arrests.

Historically (i.e., 1930s through 1950s), chronic alcoholics were the population of persons with alcohol problems to whom treatments were first directed. This is understandable, since Alcoholics Anonymous did not start until the mid-1930s and few treatment programs existed prior to that time. Severely dependent individuals were not only those most in need of services, but also the most visible. The concern was with persons who were at risk of dying from drinking-related problems or from severe withdrawals. With an absence of services, and the aura of life-threatening illness, the first priority for health care was to save lives.

While there is not much of a research basis for the use of very intensive treatments with these serious cases, given the low level of functioning of chronic alcoholics, it is clear that many circumstances may need to be addressed for any treatment to be effective. Thus, if the person has no place to live, it is reasonable to think that treatment involving alternative living arrangements would be conducive to recovery. It also may be necessary to help the individual develop a different social environment—one that supports recovery by removing the alcoholic from drinking situations. Other services such as vocational rehabilitation might also be necessary. In terms of treatment

aimed at behavior change including cessation of drinking, it might be appropriate to use a fairly directive approach, where the individual is advised and instructed how to act, rather than using an approach that depends on complex thought processes. Even though it has not yet been empirically demonstrated, persons with alcohol-related brain dysfunction would seem poor candidates for approaches that involve considerable abstract reasoning and self-direction. Consequently, the treatment procedures described in this book, which rely on intact cognitive capacities, are not intended for persons who may have brain damage.

What about people who do not fit the definitional criteria of the chronic alcoholic but whose drinking causes them difficulties? Such individuals are often referred to as "problem drinkers." As described in more depth in Chapter 3, problem drinkers typically have either experienced negative consequences of their drinking or drink in ways that place them at risk of such consequences; however, they usually do not drink steadily, do not show major withdrawal symptoms when they stop drinking, and sometimes drink with control, and their lives do not revolve around drinking.

As the result of epidemiological investigations, problem drinkers began to receive attention in the late 1960s and early 1970s. However, despite this recognition, in the ensuing years the treatment system has neither changed nor expanded to accommodate problem drinkers.

In Chapters 2 and 3 we consider problem drinkers as a group in need of different services from those currently available, and we address how the notion of "progressivity" has impeded responding to this need. The issue is not simply that the alcohol field has failed to recognize the need to provide alternative services for problem drinkers, but that clinical practice in the field is discordant with research findings. Even with respect to more serious cases of alcohol problems for which conventional treatments were developed, the procedures demonstrated in the research literature as cost effective have been ignored in clinical practice (Miller & Hester, 1986a). This is probably due to a lack of accountability for treatment effectiveness that has existed until recently (Gordis, 1987; Holden, 1987) and to the fact that the majority of today's treatments are based on a set of strong beliefs about alcohol problems.

In most health care fields practitioners are eager to learn about and to apply research advances in their practice. In the alcohol field, this is different; many practitioners are not interested in research unless it is consistent with their own beliefs.

The Role of Outpatient Services

Since alcohol problems come in many types and severities, a logical premise is that different individuals will respond best to different types of treatment.

Here it is helpful to visualize a continuum of services that vary in the intensity of interventions. Often there will be considerable correspondence between the problem severity and the intensity of the intervention. A main consideration in recommending treatments will be the extent to which the interventions will consume resources, will intrude upon a person's life, and will require lifestyle changes. Obviously more demanding and costly treatments should be reserved for those who have serious problems or impairment. Against this background, and with the understanding that we are not arguing that there is no role for intensive treatments, there are difficulties with prescribing intensive interventions for all types of alcohol problems.

In order to understand and appreciate why outpatient treatment is important, it is helpful to consider addictions services in the context of other health and mental health services. Over the past several years, serious concern has developed about the cost of health care services. From the standpoint of government, there are real economic limits to the amount of public funding that can be dedicated to health care. This is especially true in countries like Canada and Great Britain where health services are wholly publicly funded. Since in such countries nearly all health care costs are paid out of tax revenue, the costs are tied directly to the economy. Very serious attention is given to cost containment because higher costs ultimately mean higher taxes. In the United States some health services are publicly funded but most are provided by private health insurance. Since the costs usually are not directly paid by the government, pressure for cost containment has in the past come from insurance carriers. More recently, however, the need to contain health care costs has become part of the national political agenda and runaway health care costs have been viewed as a major impediment to economic growth. From a government perspective, concern for those with health and mental health problems must be balanced with the need to support other important priorities, such as education and care for the elderly. Consequently, those responsible for formulating public policy must ensure that the funding is spent in ways that are equitable and efficient. In medicine, for example, it is expected that the use of hospital beds will be restricted to cases where inpatient stays can be justified. The concern is not to save money but rather to assure that limited resources are used wisely in order to benefit as many persons as possible. This is one of the natural forces that has contributed to the rise of outpatient treatments.

An important factor encouraging the growth of outpatient services for alcohol abusers has been repeated studies showing that for many individuals in this population, outpatient treatment produces as good an outcome as inpatient treatment. This issue has been investigated for alcohol problems at varying severities, but it is particularly supported for problem drinkers.

We want to stress that when evaluating comparative treatment research, the key question is not whether one treatment is as effective as another, but

whether a more expensive or demanding (from the client's view) treatment produces a sufficiently superior outcome to warrant the additional cost or personal investment. Several studies have now examined the relationship between length of inpatient treatment and treatment outcome for alcohol problems (reviewed by Annis, 1986a, and Miller & Hester, 1986a). The findings are straightforward. Controlled studies, without exception, have found no advantage for longer over shorter inpatient treatment, whether treatment occurs over several days or weeks. Taking the issue a step further, one can ask whether residential care is even necessary. Two controlled studies have compared day treatment with inpatient treatment for alcohol problems (McCrady et al., 1986; McLachlan & Stein, 1982) and both found no differences between the two treatments.

Several controlled studies have compared the effectiveness of inpatient versus outpatient treatment for alcohol problems. Edwards and Guthrie (1967) randomly assigned 40 male alcohol abusers either to inpatient treatment averaging 9 weeks in length or to outpatient treatment averaging 7.5 sessions. Not only were no differences found between the groups over a 1-year follow-up but trends for differences favored the outpatients.

A study by Kissin, Platz, and Su (1970) is also informative despite a serious design problem and a low (49%) follow-up rate that makes the findings inconclusive. Alcoholics ($n = 458$) were assigned to either outpatient alcohol treatment, outpatient psychotherapy, inpatient rehabilitation, or no treatment. Unfortunately, random assignment was violated as clients assigned to inpatient treatment were allowed to substitute one of the two outpatient treatments if they wished. Two thirds of those assigned to inpatient treatment chose outpatient treatment instead. While this violation of random assignment destroys the value of the study as a comparative effectiveness evaluation, it demonstrates very clearly that a high percentage of individuals prefer outpatient to inpatient treatment, which bears on the issues of acceptability of treatments to clients and matching of clients to treatments.

Pittman and Tate (1969) randomly assigned 255 alcoholics to either 6 weeks of inpatient treatment plus aftercare or to detoxification lasting 7 to 10 days. At 1-year follow-up, no differences were found between groups. Another study (Stein, Newton, & Bowman, 1975) compared alcoholics who after inpatient detoxification were randomly assigned to outpatient aftercare or to a 25-day inpatient treatment. A 13-month follow-up found no significant differences between groups. Finally, Wilson, White, and Lange (1978) randomly assigned 90 alcoholics to either inpatient or outpatient treatment. At 5-month follow-up, fewer alcoholism symptoms were found for the outpatient group, but by a 10-month follow-up these differences had disappeared.

A controlled study that did not explicitly evaluate inpatient against outpatient treatment but that has direct relevance for the development of self-management treatment is the classic trial of "treatment" and "advice" by

Edwards and his colleagues (Edwards, Orford, et al., 1977; Orford, Oppenheimer, & Edwards, 1976). In that study, 100 married male alcoholics were randomly assigned to receive either a standard package of care that could include outpatient and/or inpatient treatment or to receive a single outpatient session of advice. Although a 2-year follow-up found no difference in outcome between the groups, a trend was noted. More severely debilitated clients had better outcomes when provided the full package of care, and those with less-severe problems did better with a single session of advice. These findings, however, were based on a small number of cases.

In summary, the study by Edwards and his fellow researchers and the other controlled studies reviewed have consistently failed to find evidence that inpatient treatment for alcohol problems produces superior outcomes over outpatient treatment, except for the more impaired clients in the study by Edwards and his colleagues. On this basis alone, outpatient treatment is a more cost-effective alternative to inpatient treatment for the less-impaired alcohol abuser.

Nonintensive Outpatient Treatments

Another type of intervention that has begun to receive widespread attention as a broad public health response to alcohol and drug problems has been called "brief advice," "early intervention," or "brief intervention." This strategy got its initial impetus from a study of smokers by Russell, Wilson, Taylor, and Baker (1979) in Great Britain. These researchers demonstrated that if cigarette smokers were simply advised by their physicians to stop smoking, particularly if they were also provided with a short pamphlet on tips for stopping smoking, about 5% stopped smoking at a 1-year follow-up compared to only 1% to 2% of patients who were not advised to stop smoking. While this finding may not seem dramatic, the results are important when one considers that the vast majority of adults visit their physician at least once every 5 years. Russell estimated that if all general practice physicians in Great Britain advised their smoking patients to stop smoking, this would yield about half a million ex-smokers per year. In contrast, he estimated that it would take at least a 200-fold increase in smoking-cessation clinics to yield an equivalent number of ex-smokers. In terms of the overall health care system, this study revealed a highly cost-effective countermeasure for helping people stop smoking.

A similar strategy has been used to encourage heavy or problem drinkers to reduce or cease their drinking. Interestingly, most of these interventions have not been in response to an individual's request for treatment. Instead, they often involve individuals identified as excessive drinkers by primary care clinicians (typically physicians). An example of such a study with drinkers

was reported by Persson and Magnusson (1989). Of 2,114 patients attending somatic outpatient clinics in Sweden, 78 were identified as either reporting excessive alcohol consumption on a questionnaire or as having abnormal liver serum enzyme levels on a blood test. These patients were randomly assigned either to a control group or to a limited intervention that involved an interview with a physician followed by monthly checkups to gather information on the patients' drinking and enzyme levels and to provide patients with feedback. Those patients given the intervention showed positive effects for all of the main variables examined (e.g., drinking levels, serum enzyme levels) over the course of the intervention.

Other studies with less patient contact have yielded similar findings (Chick, Lloyd, & Crombie, 1985; Kristenson, Öhlin, Hultén-Nosslin, Trell, & Hood, 1983; Kristenson, Trell, & Hood, 1981). Such studies are usually hospital or clinic based, and the intervention seldom consists of more than advice to reduce drinking and education about the health risks associated with heavy drinking. Typically, little evidence is provided that the targets of the advice have experienced serious life problems related to their drinking. A similar strategy, but in a nonmedical setting, has been reported by Miller and his colleagues (Miller & Sovereign, 1989; Miller, Sovereign, & Krege, 1988). A "Drinker's Check-up" was offered to the public through media advertisements. Thus far, short-term significant decreases in alcohol consumption have been reported.

With regard to helping persons who self-identify as having alcohol problems, brief interventions have also been positively evaluated. One of the best known studies, conducted by Edwards and his colleagues (1977), has already been discussed. In contrast to Edwards and his fellow researchers, most minimal interventions have been specifically directed at problem drinkers. These treatments usually allow goals of reduced drinking or abstinence or allow clients to choose their own goal (reviewed in Institute of Medicine, 1990), and they often use self-help manuals and/or one or more sessions of counseling. (See Babor, Ritson, & Hodgson, 1986, Heather, 1989, Institute of Medicine, 1990, and Saunders & Aasland, 1987, for reviews of these studies.)

Very often studies of self-identified problem drinkers have found very brief treatments, and sometimes even bibliotherapy (self-help manuals used by clients), to be as effective as more intensive outpatient treatments. For example, Chick and his colleagues (Chick, Ritson, Connaughton, Stewart, & Chick, 1988) randomly assigned 152 clients at an alcohol clinic either to one session of simple advice (5-minute discussion where the client was told that he or she had an alcohol problem and should stop drinking), one session of amplified advice (30- to 60-minute discussion intended to increase the client's motivation to change), or extended treatment that included amplified advice plus individualized further help that could have involved inpatient or day treatment. At a 2-year follow-up, the extended treatment group had

suffered less harm from their drinking, but abstinence and problem-free drinking rates did not differ significantly between the treatments.

The study by Chick et al. (1988) was exceptional in the use of an inpatient condition and a 5-minute advice condition. More typical of studies comparing the intensity of outpatient treatment is a study reported by Zweben, Pearlman, and Li (1988). Married couples in which at least one of the partners had an alcohol problem were randomly assigned to eight sessions of conjoint therapy or to one session of conjoint advice and counseling. At the 18-month follow-up there were no differences between the treatments on any outcome measures. Another similar study was reported by Skutle and Berg (1987). Problem drinkers received either 4 hours of instruction in the use of a self-help manual or were assigned to one of three other treatments involving 12 to 16 therapist-directed outpatient sessions (e.g., coping-skills training). At 1-year follow-up, there were no differences between the treatments.

Other studies comparing different amounts of outpatient treatment for alcohol abusers are described in the reviews mentioned earlier. Many of these studies involved relatively small sample sizes, and thus differences between treatments would have to be large to be evaluated as statistically significant (Kazdin & Bass, 1989). However, even when the issue of sample size has been taken into account, no superiority has been demonstrated for more intensive over less intensive treatments (Hall & Heather, 1991).

The above conclusions about the generally equivalent effectiveness of intensive and nonintensive treatments derive from studies where nonselected populations were assigned to treatments. That is, all of the eligible subjects for a given study were assigned nonsystematically among the treatments. While it is possible that some individuals respond particularly well to intensive treatment and others to nonintensive treatment, these interactions cannot be discerned from studies conducted to date. A matching strategy, where clients are purposely assigned or misassigned to treatments thought to "match" their needs would shed some light on this question (Miller & Hester, 1986b). The conduct of high quality prospective matching research, however, is a complicated and resource consuming enterprise (Finney & Moos, 1986).

Several of the following chapters are devoted to a consideration of the literature on issues related to the development and application of self-management treatment of alcohol problems. Although we have written about many of these issues and procedures previously (e.g., L. C. Sobell & M. B. Sobell, 1973, 1983, 1992b; Sobell, Sobell, & Nirenberg, 1988; M. B. Sobell & L. C. Sobell, 1978, 1986/1987; Sobell, Sobell, & Sheahan, 1976), we have never before tied these topics together. That intergration is the primary goal of this book.

2

The Recognition of Problem Drinkers

Services tailored to problem drinkers have been neglected for several reasons. First, workers in the alcohol field have not made services for problem drinkers a priority. Second, many therapists may be uncomfortable with suitable alternative treatments for problem drinkers as they often involve brief treatment and a reduced-drinking rather than abstinence goal (Sanchez-Craig, 1990; Sanchez-Craig & Wilkinson, 1986/1987; M. B. Sobell & L. C. Sobell, 1986/1987). In our view, however, the major reason why appropriate treatments for problem drinkers have not been offered is conceptual, relating to the traditional notion that alcohol problems are a progressive disorder.

Are Alcohol Problems Progressive?

To suggest that alcohol problems are progressive means that once the problems develop, they will inevitably worsen and follow a predictable course of symptoms if drinking continues. Several decades ago this concept was applied to alcohol problems by Jellinek (1946, 1952, 1960a, 1960b). The main problem with the notion of progressivity is that it lacks empirical support.

The basic approach used by Jellinek and others-who have attempted to replicate his work (reviewed by Pattison, Sobell, & Sobell, 1977) involved retrospectively interviewing severe alcoholics and having them reconstruct the temporal ordering of symptoms they had experienced. Interestingly, Jellinek's first study was not planned. The then-fledgling self-help organization, Alcoholics Anonymous (AA), had prepared a questionnaire that was distributed in their newsletter, the Grapevine. The questionnaire provided respondents with a list of symptoms and asked them to indicate in what year they had experienced each symptom. Of approximately 1,600 questionnaires distributed through the Grapevine, 98 were returned and usable. Jellinek was

then asked by AA to analyze the returns, and he agreed, despite knowing the research problems that plagued that survey. Paramount among these were: (1) the sample was highly selective (the typical subject was a long-time member of AA and well versed in AA writings); (2) the subjects were only asked to indicate when a particular event first happened; and (3) the list of potential events was generated by the staff of the Grapevine. Nevertheless, Jellinek analyzed and reported the data, and the notion that alcohol problems follow an inexorable course was born.

Later studies of progressivity, while not as biased in design or in the demands placed on subjects, still obtained retrospective data from severely dependent alcoholics. Although these studies do not agree on the exact ordering of symptoms (see Mandell, 1983), typically severe alcoholics do report that they experienced less serious symptoms earlier in their problem drinking career. Such reports tell us that persons with severe problems will report that they experienced less severe problems in the past, but they do not address the central issue of progressivity. That is, they fail to assess whether people who have an alcohol problem at one time and continue to drink will have a worse problem at a later time.

The appropriate way to determine whether alcohol problems are progressive is by prospective studies, that is, by tracking people who have been identified as having alcohol problems over time. A sizable number of longitudinal studies that have used this methodology have overwhelmingly demonstrated that a minority of cases (about 25–30%) do show a progressive development of alcohol problems (i.e., they worsen over time with continued drinking) (Fillmore, 1988; Mandell, 1983). The more common pattern, however, is one of people moving into and out of periods of alcohol problems of varying severity, with problem episodes separated by periods of either abstinence or of drinking without problems (Cahalan, 1970; Cahalan & Room, 1974; Pattison et al., 1977). Except in a few cases where persons have fairly advanced problems (Fillmore & Midanik, 1984), it is not possible to predict with any confidence that an individual who has an alcohol problem and does not get treatment will still have problems at a later time. It is also impossible to predict how severe the problems will be if they continue. One recent study, for example, found that some persons' problems are less serious at a later point in time (Hasin, Grant, & Endicott, 1990). Findings such as these have led some (e.g., Hill, 1985; Kissin, 1983) to hypothesize that problem drinkers may be qualitatively different from individuals who become chronic alcoholics, and that problem drinkers may never progress to being severely dependent on alcohol. This thesis awaits empirical test.

Despite the lack of evidence for progressivity, the notion is deeply ingrained in the field's thinking about alcohol problems. For example, the *Seventh Special Report to the U.S. Congress on Alcohol and Health* (1990) by the National Institute on Alcohol Abuse and Alcoholism states that "7.2 million abuse alcohol, but do not *yet* show symptoms of dependence" (p. ix, italics added). The word "yet" conveys a clear expectation that these individuals will become dependent unless they are steered from that course.

The progressivity notion is the pivotal justification for the position that anyone with identifiable alcohol problems, regardless of severity, should receive the same treatment. The assumption is that alcohol problems form a uniform disorder, and unless an individual who has developed alcohol problems ceases drinking the disorder will intensify to chronic alcoholism. Many existing treatment approaches are predicated on the notion that anyone who is identified as having an alcohol problem is in the midst of a progressive deterioration into full-blown alcoholism unless they stop drinking. If this approach is taken, then all cases are viewed as suitable for the same treatment because the primary difference between individuals is that some have deteriorated less than others when they enter treatment.

To date, the primary benefit of recognizing problem drinkers has been an increased emphasis on early case identification (Weisner & Room, 1984/1985). This, unfortunately, has led to routing such individuals to conventional treatments. A major element of "early interventions" based on the progressivity notion is an emphasis on convincing such individuals of the futility of their attempting to control their drinking. As illustrated in the next chapter, most problem drinkers do not drink excessively every time they drink. Often they limit their alcohol consumption to nonhazardous levels. Thus, the subjective experience of most problem drinkers contradicts the edict that they lack control over their drinking.

A major field demonstration of how service providers fail to distinguish problem drinkers from chronic alcoholics was reported several years ago by Hansen and Emrick (1983). The authors studied the fates of trained actors sent to five inpatient treatment centers and one outpatient treatment center to be evaluated for treatment of a possible alcohol problem. The five actors were trained to represent varying levels of drinking-problem severity: one was trained to present as someone who was an alcoholic in the past but who had achieved a stable non-problem-drinking recovery and actually needed no treatment; the other four were trained to present as problem drinkers, none of whom would qualify for a diagnosis of alcohol dependence and none of whom would require inpatient treatment. The authors concluded that "there was no apparent consistency as to who was considered 'alcoholic' nor was any relationship observed between the severity of the symptoms presented and the treatment recommended" (p. 164).

Prevalence of Problem Drinkers

In Chapter 1, we briefly mentioned that problem drinkers constitute a much larger group than severely dependent drinkers. In fact, considerable epidemiological and longitudinal research supports this conclusion. In the early 1970s,

when the alcohol field started to gain visibility as an area of research, epidemiological studies began reporting compelling evidence that the very chronic alcoholics who had the public's eye were only the tip of the iceberg of individuals with alcohol problems. In a national survey of alcohol use in the United States, Cahalan (1970) found that 15% of men and 4% of women had experienced multiple alcohol problems at some time during the 3 years preceding the interview. If a more liberal criterion of alcohol problems is employed, these rates increase to 43% for men and 21% for women. Yet, only a small percentage of respondents reported experiencing alcohol withdrawal symptoms. Although it is impossible to calculate the actual prevalence of severe dependence in Cahalan's sample, the important point is that many people had alcohol problems without accompanying physical dependence.

In another study that conducted a random survey of U.S. Air Force personnel, Polich (1981) found that 4.6% of respondents could be classified as alcohol dependent (symptoms of withdrawal and impaired control over drinking), whereas 9.5% could be classified as nondependent alcohol abusers (based on serious adverse effects of drinking or consumption of >150 ml of ethanol daily). Noting that these findings were based on a selected subgroup within the general population, Polich compared his results with those of major epidemiological studies. He concluded that "the comparative analysis of problem drinking among civilians and military personnel reveals no striking differences between them, after demographic differences are taken into account" (p. 1131). In a Scandinavian study of middle-aged males in the general population, Kristenson (1987) found that 5.4% were alcohol dependent, whereas 9.4% had alcohol-related problems but were not dependent. Similar studies have been reported by Cahalan and Room (1974) and by Hilton (1987, 1991).

Besides the survey findings, several longitudinal studies have examined the prevalence of alcohol problems at a given time as well as interviewed individuals on two or more occasions. These studies have not only failed to support the notion of progressivity but they have also provided evidence for the prevalence of problem drinking. For interested readers, the literature on longitudinal studies has been impressively summarized by Fillmore (1988).

In addition to the general population studies, problem drinkers can also be found in treatment programs. Skinner and Allen (1982) found that alcohol abusers who had voluntarily entered treatment and scored below the median on the Alcohol Dependence Scale were likely to report no history or signs of physical dependence on alcohol, to not self-identify as alcoholic, and to not perceive a need for abstinence as the goal of treatment. Further evidence of problem drinkers in treatment is discussed in Chapter 3, where characteristics of problem drinkers are considered in greater detail.

A recent report by the Institute of Medicine to the NIAAA suggests that the ratio of problem drinkers to those seriously dependent on alcohol is about

4:1 (Institute of Medicine, 1990). As discussed in Chapter 1, the exact ratio of problem drinkers to more severely dependent individuals will depend on the definitions used (Hilton, 1991). Whatever the definition, the important point is that by any reasonable definition, the population of problem drinkers is quite large, and it is considerably larger than the population of persons who are severely dependent on alcohol (Room, 1977, 1980; Skinner, 1990). Clearly, problem drinkers form a sizable population that manifests alcohol problems, but they do not fit the conventional stereotype of individuals physically and chronically dependent on alcohol. The distribution of alcohol use in the adult population is graphically displayed in Figure 2.1, which reflects the estimates by the Institute of Medicine, as well as a gray area of a range of estimates derived from other classifications in which different criteria were used for making the distinction between severely dependent and problem drinkers.

To this point, we have considered how the alcohol field has gradually come to recognize the existence of problem drinkers, a sizable population of

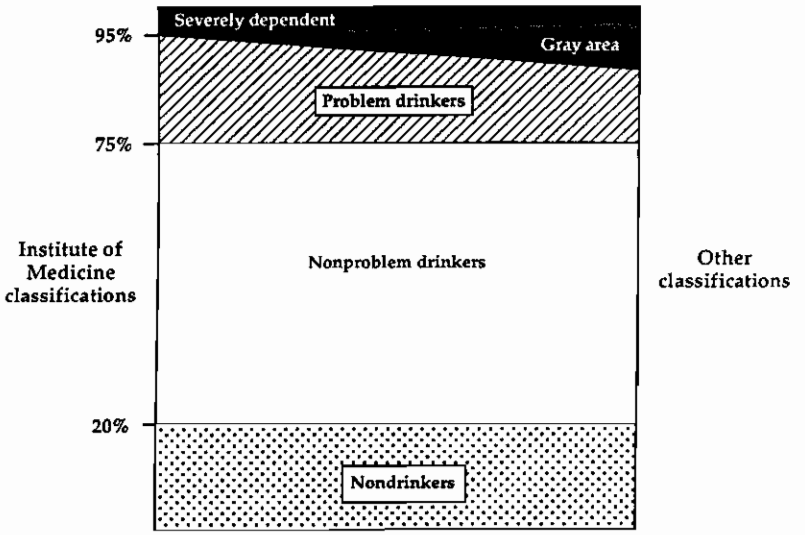

FIGURE 2.1. Distribution of alcohol use in the adult population. From "Treatment for Problem Drinkers: A Public Health Priority" by M. B. Sobell and L. C. Sobell, 1993, in J. S. Baer, G. A. Marlatt, and R. J. McMahon, eds., *Addictive Behaviors across the Lifespan: Prevention, Treatment, and Policy Issues*, Beverly Hills, CA: Sage. Copyright 1993 by Mark B. Sobell and Linda C. Sobell. Adapted by permission.

individuals with alcohol problems. In Chapter 3, we will consider how problem drinkers differ from more severely dependent persons with alcohol problems, and in Chapter 4, we will cover why problem drinkers require different interventions from the intensive treatments that currently dominate the alcohol treatment system.

3

A Closer Look at Problem Drinkers

Studies of Problem Drinkers

Although there is a tendency to consider alcohol problems as a unitary phenomenon, in reality alcohol problems are quite heterogeneous. About the only thing such problems do have in common is that they represent adverse consequences related to alcohol consumption.

Several years ago, Thorley (1980) suggested that three major types of alcohol problems could be distinguished. The first category involves problems related to acute intoxication (e.g., accidental injuries, arrests for drunk driving, fights). The second category includes problems related to regular heavy drinking. Although such problems often involve health consequences (e.g., cirrhosis), other consequences can occur (e.g., financial, marital). These consequences occur in individuals who are seldom "drunk" and who are not physically dependent on alcohol. Jellinek (1960b) noted such consequences among some Europeans who regularly consumed large amounts of wine but seldom in a pattern that would produce a high blood alcohol level. The World Health Organization (WHO) considers these two categories of problems to constitute "alcohol-related disabilities" (Edwards, Gross, Keller, Moser, & Room, 1977).

The final category of alcohol problems consists of problems related to dependence, including the manifestation of alcohol withdrawal symptoms upon the cessation of drinking and consequences related to long periods of intoxication (e.g., job loss). This category combines the WHO categories of alcohol-related disabilities and alcohol dependence (i.e., vocational problems are considered an alcohol-related disability by the WHO).

While the three domains of problems will often overlap (i.e., evidence of all three types of consequences may be apparent), problem drinkers suffer largely from problems related to intoxication. Their drinking is typically not

characterized by features such as compulsive alcohol seeking, daily drinking, or by high blood alcohol levels sustained over lengthy periods of time. Yet, it is these features of severe dependence that many existing treatment programs are designed to address. The problem drinker's troubles are more related to drinking episodes that get out of hand, to consequences of drunkenness, and to recognizing that they sometimes consume more alcohol than they planned.

The costs incurred to individuals and society by problem drinkers are formidable, especially when we recall that problem drinkers are more numerous than severely dependent persons. Moore and Gerstein (1981) have reported that the majority of costs attributed to alcohol misuse relate to instances of acute intoxication among persons who are not severely dependent on alcohol. Interestingly, while these costs are eagerly used to lobby for more funding for alcohol services, when funding is received, it is devoted largely to additional services for severely dependent individuals (Cahalan, 1987; Institute of Medicine, 1990; Miller & Hester, 1986a). To some extent, this might be related to the notion of progressivity discussed in Chapter 2. From the standpoint that the same type of service is appropriate for everyone with alcohol problems, it might be argued that the additional funding was being spent for appropriate services. From a public health perspective, however, there is a serious imbalance in the provision of services compared to needs (M. B. Sobell & L. C. Sobell, 1986/1987, 1993). While the next chapter will argue for the need for different services for problem drinkers, the present chapter is devoted to better understanding the nature of problem drinkers.

First the research literature will be examined to identify some general attributes of problem drinkers and compare some of their characteristics to those of more severely dependent individuals. Then assessment data from a group of problem drinkers involved in our own research will be examined in detail.

Problem Drinkers in the Research Literature

The research literature describes problem drinkers in several ways. Since some characteristics are definitional, it would be tautological to cite them as evidence for group differences. For example, one characteristic often used to define problem drinkers is no history of physical dependence, especially major withdrawal symptoms (e.g., M. B. Sobell & L. C. Sobell, 1986/1987). The reason for using major withdrawal symptoms (i.e., hallucinations, seizures, delirium tremens) as a defining characteristic is because they can be objectively measured, whereas the presence or absence of variables such as "impaired control" or "preoccupation with drinking" requires subjective judgments.

Also, just knowing that someone has been severely dependent implies several things about the role of drinking in the person's life. For instance, to

manifest serious withdrawal symptoms upon the cessation of drinking, it is necessary to engage in very heavy drinking over an extended period of time (see Pattison, Sobell, & Sobell, 1977). Usually, consumption of the equivalent of at least 30 to 40 oz of spirits (40–50% ethanol) daily for at least a few days is required. For an individual to consume such amounts indicates: (1) considerable tolerance for ethanol, probably relating to an extensive heavy-drinking history; (2) a need to have alcoholic beverages constantly accessible since the cessation of drinking would initiate a withdrawal syndrome; (3) a work or life situation that allows such consumption either without detection or without consequences of detection; (4) the pervasion of most activities with drinking opportunities (i.e., never being very far away from a drink); and (5) in all likelihood, a constellation of consequences that accompanies a long-term heavy-drinking pattern (e.g., disrupted interpersonal relationships, vocational problems, health problems related to long-term alcohol consumption, low self-esteem, a history of failed attempts to reduce or stop drinking). Thus, while a history of severe withdrawal symptoms is only one indication of the problem, it often justifies an educated guess that the individual's lifestyle is centered around drinking and that there is a long-standing history of experiencing alcohol-related consequences.

Problem drinkers will typically score low in the distribution of scores on scales measuring alcohol dependence (Heather, Kissoon-Singh, & Fenton, 1990). They also tend to report problem drinking histories shorter than 10 years, to have fewer health and social consequences related to their drinking, and, often, to have not received prior alcohol treatment (Sanchez-Craig & Wilkinson, 1986/1987). Problem drinkers tend to have greater personal, social, and economic resources and stability than severely dependent drinkers. They tend not to view themselves as "alcoholics" or as basically different from persons who do not have alcohol problems (Skinner & Allen, 1982). There also may be a higher representation of females among problem drinkers compared to more dependent individuals, and overall alcohol consumption of problem drinkers typically is less than that of more severely dependent individuals.

An appreciation of the differences between problem drinkers and more severely dependent individuals can be achieved by comparing pretreatment characteristics of both populations as reported in the literature. Table 3.1 presents such a comparison displaying variables from eight studies involving severely dependent persons and six studies involving problem drinkers, including a study of guided self-management treatment. The severely dependent alcohol abusers were all recruited from inpatient treatment programs except for one study (Kuchipudi, Hobein, Flickinger, & Iber, 1990), which involved persons hospitalized for recurrent alcohol-related pancreatitis, ulcers, or liver disease (62% had diagnosed cirrhosis). All of the problem drinkers received brief outpatient treatment, and in all of the problem drinker studies except

TABLE 3.1. Pretreatment Variables Describing the Client Cohorts from Several Studies of Severely Dependent Alcohol Abusers and Several Studies of Problem Drinkers

Study	Pretreatment variables								
	n	Females (%)	Married (%)	Employed (%)	MAST score[a]	ADS score[b]	Education (mean years)	Age (mean years)	Drinking problem (mean years)
Severely dependent samples									
Carver & Dunham (1991)	211	0	11	44	—	—	—	36	—
Chaney et al. (1978)	40	0[c]	43	—	—	—	12	46	17
Chapman & Huygens (1988)	113	20	39	42	8[d]	—	—	42	14
Foy et al. (1984)	62	0[c]	49	40	—	—	12	46	10
Ito et al. (1988)	39	0[c]	38	36	—	20	13	36	15
Kanas et al. (1976)	137	0[c]	45	30	—	—	11	45	16
Kuchipudi et al. (1990)	114	0[c]	—	22	—	—	—	52	—
Vaillant et al. (1983)	100	13	35	27	—	—	—	45	10+[e]
Problem drinker samples									
Connors et al. (1992)	63	32	33	94	16	—	16	37	6
Harris & Miller (1990)	34	50	—	—	17	—	15	38	8
Sanchez-Craig et al. (1984)	70	26	47	—	19	14	14	35	5
Sanchez-Craig et al. (1991)	96	36	56	75	—	12	15	40	5
Skutle & Berg (1987)	43	21	63	98	—	—	13	43	—
Guided self-change study	100	36	49	88	—	13	15	37	6

[a]Michigan Alcoholism Screening Test (possible scores: 0–53).
[b]Alcohol Dependence Scale (possible scores: 0–47).
[c]Veterans Administration Program.
[d]Short version.
[e]87% had a drinking problem for more than 10 years.

the one involving guided self-management, the subjects were solicited by newspaper advertisements.

Inspection of Table 3.1 reveals that among the few descriptors for which study comparisons are possible, the problem drinkers were generally younger, had a shorter problem drinking history, and were better educated (however, any difference in education might be attributable to most problem drinkers having been solicited through media advertisement, whereas most of the severely dependent persons were self-admissions to treatment programs). The problem drinkers also showed much greater stability in terms of employment, although they did not differ substantially from the severely dependent in marital status. While most of the studies of severely dependent samples occurred at Veterans Administration hospitals and, therefore, were limited to males, the proportion of females in the problem drinker samples was greater than is typical for alcohol treatment programs (Collins, 1993).

Motivationally, two factors are important clinical considerations when working with problem drinkers. First, while problem drinkers typically have not suffered multiple serious consequences from their drinking, they usually are aware that they could suffer serious consequences if their drinking problem continues. This can provide an incentive for change. However, if treatment demands are too great, then noncompliance can be expected (Miller, 1986/1987; Pomerleau, Pertschuk, Adkins, & Brady, 1978). This occurs because problem drinkers' lives usually have not been so damaged by their drinking problems that they are ready to make large sacrifices to comply with treatment. The demands of treatment compete with their work, family, and personal needs. Since traditional treatments, and especially Minnesota Model treatments, are very demanding, this is another reason why alternative treatments are needed for problem drinkers.

In summary, the research literature tells us several things about problem drinkers as compared to more severely dependent alcohol abusers:

1. Problem drinkers do not have a history of severe alcohol withdrawal symptoms.
2. Problem drinkers tend to have a shorter problem drinking history, typically around 5 years, and seldom over 10 years.
3. Problem drinkers tend to have greater social and economic stability.
4. Problem drinkers tend to have greater personal, social, and economic resources to call upon in treatment (i.e., they have more opportunity to help themselves).
5. Problem drinkers are not likely to view themselves as different from persons who do not have drinking problems (i.e., they do not self-identify as alcoholic, and their self-esteem is usually higher than persons with more severe histories).

6. Problem drinkers can become caught in a motivational dilemma, knowing that they still have a great deal to lose but also feeling that conditions in their life are not so bad as to justify extensive life changes or sacrifices to deal with their drinking.

The above are some of the conclusions that can be drawn from the literature on problem drinkers. A detailed look at a group of problem drinkers will be helpful in conveying a more complete picture and understanding of such individuals.

A Close Look at a Group of Problem Drinkers

A brief look at some of the problem drinkers we recently treated in a study at the Addiction Research Foundation will support many of the features discussed above. These individuals were voluntary admissions to a treatment agency. They did not respond to advertisements as has been common in research studies of treatments for problem drinkers (e.g., Miller, Taylor, & West, 1980; Sanchez-Craig, Annis, Bornet, & MacDonald, 1984; Sanchez-Craig, Leigh, Spivak, & Lei, 1989). That these clients presented themselves for treatment is important because another study conducted at the same agency that used walk-in and solicited clients found that the two groups differed in an interesting way (Zweben, Pearlman, & Li, 1988). Clients solicited by advertisement described themselves as heavier drinkers and perceived themselves as more dependent than those who had sought out treatment. Ad respondents also reported having suffered fewer consequences from their drinking. Two other studies of problem drinkers have reported similar results (Sobell, 1993; L. C. Sobell & M. B. Sobell, 1992a; Hingson, Mangione, Meyers, & Scotch, 1982). These results suggest that it might be the impact of drinking-related consequences rather than the excessiveness of the drinking that motivates problem drinkers to seek treatment.

The 100 problem drinkers we will consider volunteered to participate in a treatment research study with a self-management orientation. Although the literature suggests, as will be discussed in Chapter 4, that many problem drinkers have the capacity to assume the major responsibility for planning and implementing their own behavior-change strategies, the clients discussed here explicitly entered a treatment having that expectation.

Clients' mean age was 37.3 years (range = 21–59 years), and they reported having had alcohol problems for an average of slightly more than 6 years. Although there is a tendency to expect that problem drinkers will be young (perhaps a derivative of the progressivity notion), many clients could be described as having a "middle-age onset" of their problems, a phenomenon reported several times in the literature (Atkinson, Tolson, & Turner, 1990; Fillmore, 1974; M. B. Sobell & L. C. Sobell, 1993).

Some clients in their fifties, for example, had only experienced drinking problems for a few years prior to entering treatment. Thus, at this time, orienting treatment programs for problem drinkers toward specific age groups does not appear warranted.

This group of problem drinkers also showed good evidence of social stability: 88% were employed, and 49% were married. The average education level was nearly 15 years, and 87% had at least a high school education. In another study at the same agency with a different group of outpatients (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992), it was found that those who had at least some university education were significantly more likely to prefer to select their own treatment goal than were those with less education. It may be that education level is a characteristic of the problem drinker population that is attracted to self-management treatments. In areas other than alcohol problems, it has been found that better educated, older adults were most likely to complete self-administered treatment programs (Scogin, Bynum, Stephens, & Calhoon, 1990).

In summary, a typical problem drinker client could be described as a mature, socially stable adult. A final important demographic characteristic is that 36% were female compared to about 21% of the total outpatient admissions to the treatment agency from which the sample was drawn. Sanchez-Craig has suggested that females may find a self-management approach to be particularly appealing (Sanchez-Craig, 1990).

In terms of drinking behavior, an important qualifying condition for the study of self-management treatment was that persons who reported heavy drinking (i.e., $\geq$12 drinks on $\geq$5 days per week for the 6 months prior to admission) were not eligible for the evaluation. Consequently, the sample reported here may be biased toward lighter-drinking problem drinkers. What is important, however, is that these clients definitely had alcohol problems when they sought treatment, although they were not severely dependent on alcohol.

Several features of these clients' drinking for the year prior to entering treatment are of interest and have implications for treatment planning. Pretreatment drinking was assessed using the Timeline Follow-Back method (see Chapter 6; L. C. Sobell & M. B. Sobell, 1992b; Sobell, Sobell, Leo, & Cancilla, 1988). First, daily drinking was uncommon among this population. As a group, they drank on only 68.2% of all days during the year, meaning they were abstinent on about 1 out of every 3 days. Second, when they did drink, on 38.7% of those days they drank $\leq$4 standard drinks (1 standard drink = 0.6 oz of pure ethanol, or 13.6 gm of absolute alcohol). Thus, on nearly 4 out of every 10 drinking days their drinking involved very low amounts. Third, the mean number of drinks they consumed per drinking day was 6.4. This level amounts to an average of a little over 30 drinks per week.

In a study of medical-ward patients with and without alcohol problems, Lloyd, Chick, Crombie, and Anderson (1986) found that a criterion equal to approximately 26 drinks per week was the best cutting point for separating problem and nonproblem drinkers. Sanchez-Craig (1986) found that 12 standard drinks per week (no more than 4 drinks per day on no more than 3 days per week) best distinguished problem-free from problem drinkers. Finally, Hester and Miller (1990) and Harris and Miller (1990) have recommended a weekly limit of 17.5 standard drinks as a success criterion for reduced drinking. While the cohort reported here may have been relatively light drinkers among persons with alcohol problems, prior to treatment they were drinking at or above hazardous levels.

Finally, the mean percent of pretreatment drinking days that involved very heavy drinking, defined as ten or more standard drinks, was 16.8%. Although comparison data are not available, such drinking is probably well below the level of heavy drinking exhibited by severely dependent drinkers. Persons who drink without any problems, however, probably do not consume at least ten drinks on nearly 1 out of every 5 drinking days. In summary, the drinking of our problem drinkers, while not extremely heavy, exceeded hazardous levels and was at a level found to be associated with problem drinking in other studies.

The final major domain of subject characteristics to be discussed is consequences of drinking. In contrast to their pretreatment drinking, the clients reported an abundance of pretreatment drinking-related consequences, perhaps supporting the suggestion from Zweben, Pearlman, and Li (1988) that persons who voluntarily seek out treatment are more likely to have suffered consequences of their drinking. For example, 81% of the clients in our study reported interpersonal problems related to their drinking, 48% reported vocational problems, 78% reported cognitive impairment, 27% reported health problems, 47% reported financial problems, 26% reported an alcohol-related arrest, and 8% reported an alcohol-related hospitalization. Also, 93% reported that they had felt a need for alcohol, 47% stated they had perceived an increase in their tolerance to alcohol, and 42% reported they had at some time felt tremulous as a result of stopping drinking. Moreover, the clients had an average Alcohol Dependence Scale (ADS) score of 12.9 (about the 25th percentile on the norms for that instrument), and due to screening criteria none of them exceeded an ADS score of 21 (the median). Validation studies of the ADS have found withdrawal phenomena to be rare in individuals who score in this range (Skinner & Allen, 1982).

We also asked the clients to subjectively evaluate the severity of their drinking problem during the year prior to treatment using an operationally defined 5-point scale. This was done because for some of the clients, especially those who chose a reduced-drinking goal, it would have been difficult to demonstrate a statistically significant reduction in their drinking in our relatively small sample. Thus, had objective drinking behavior been the only measure, a clinically important change might not have been detected by statistical analysis. The scale we used is shown as Table 3.2.

Overall, 78% of the clients in our study reported that they had suffered at least one serious alcohol-related consequence during the pretreatment year: 56% rated their pretreatment problem as Major, and 22% rated their pretreatment problem as Very Major. No clients reported that their pretreatment drinking was Not a Problem. However, 15% reported that their pretreatment drinking was a Minor Problem, and 7% evaluated it as a Very Minor Problem, the latter meaning that they worried about their drinking but had suffered no identifiable consequences.

In this chapter we focused on describing the problem drinker. In Chapter 4 we provide a review of the research on the treatment of the problem drinker. After summarizing that research, in Chapter 5 we then consider what features of a treatment might appeal to problem drinkers and how treatment for problem drinkers could be easily accomplished by service providers in the community. Attention to the ease of delivery of a treatment in regular clinical settings (as opposed to research settings) is extremely important if there is any hope that a research-based treatment will be adopted by community programs. In the main study in which the guided self-management procedures were evaluated (the focus of this book), 85% of the clients were seen by outpatient therapists rather than by researchers.

TABLE 3.2. Rating Categories for Clients' Subjective Evaluation of the Severity of Their Drinking Problem (Used Pretreatment and Posttreatment)

Not a Problem	—
Very Minor Problem	Worried about it but not experiencing *any* negative consequences from it
Minor Problem	Experiencing some negative consequences from it, but *none* that I consider serious
Major Problem	Experiencing some negative consequences from it, *one* of which I consider serious
Very Major Problem	Experiencing some negative consequences from it, *at least two* of which I consider serious