Chapter 4

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THE DRINKING DILEMMA

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By calling abstinence the only cure, we ensure that the nation's $100 billion alcohol problem won't be solved

"Would you like something to drink?" the waitress asks Elisa DeCarlo as she plops into a chair in an Asian restaurant on Manhattan's Upper West Side. DeCarlo, a 37-year-old actress, would love something to drink. She has just finished a performance of her one-woman show at an off-off-Broadway theater. Only a dozen people showed up, and they laughed in the wrong places. After a show, when she is thirsty and wound up, is the time she loves a drink most.

"Nothing at the moment, thank you," DeCarlo says, reaching for a water glass and draining it. She drinks two more glasses of water and waits for the food to arrive before ordering a good French pinot blanc. By the end of the night, she's had three glasses of wine; more than her usual two, but still within the limits of Moderation Management, the controlled-drinking self-help program she has followed for the past 16 months. A self-described problem drinker who used to pound down so much booze after a show she felt lousy the next morning, she had checked out Alcoholics Anonymous but was put off by the group's famous first step: "We admitted we were powerless over alcohol--that our lives had become unmanageable."

"If you choose to overdrink, you choose to overdrink and you know it," DeCarlo says. She was happily married; she had published two novels; she toured nationally. She didn't feel that her life was unmanageable, just that alcohol was taking up too much of it. Following Moderation Management guidelines, she quit drinking for 30 days and now takes no more than nine drinks a week, no more than three a day, and never drinks and drives. (The guideline's limit for men is 14 drinks a week, four on any given day.) "It's a really nice feeling to know I can have a drink and stop and feel fine the next day," she says. "It's made a tremendous difference. My life is too interesting to mess it up with a drinking problem."

DeCarlo's strategy is, depending on how you look at it, either the best hope for problem drinking in America or the most threatening form of self-delusion. She and other imbibers experimenting with controlled-drinking programs around the country have innocently stumbled into the most hotly contested issue in alcohol treatment: whether cutting back, as opposed to total abstinence, is an option for some people who drink too much.

Narrow path. There are 40 million problem drinkers in the United States--people whose drinking causes economic, physical, or family harm but who are not technically alcoholic (defined as being physiologically dependent on alcohol). But for the past six decades, beginning shortly after Prohibition was repealed in 1933, treatment for drinking problems in this country has focused almost exclusively on alcoholics, has offered abstinence as the sole cure for their problems, and has laid just two paths to that cure: Alcoholics Anonymous, the spiritual self-help group founded in 1935; and a

variety of related 12-step programs, originally developed at the Hazelden Foundation and other Minnesota clinics in the 1950s, which combine psychological and peer counseling and AA attendance. (AA is the granddaddy of 12-step programs, but the two approaches are not synonymous. AA is a self-help group aimed at sobriety and spiritual renewal; 12-step alcohol-treatment programs adopt some of AA's tenets but include a wide array of secular treatments, from psychotherapy to acupuncture.)

A U.S. News reporter, querying a dozen treatment centers about her options as someone concerned about her drinking, was offered only abstinence-based programs. The Mayo Clinic told her she was welcome to try cutting back on her own and then to come back if she failed. At the Betty Ford Center, a kindly woman answering the phone said, "For people like us, one drink always leads to another. You may be functional now, but it's progressive."

The problem with that advice is that for many people it's not true. For at least the past decade, researchers have known that the majority of people who drink heavily don't become alcoholics; some experts place that number as high as 75 percent. Other drinkers may meet the clinical criteria for alcohol dependence but can sustain controlled drinking for months, even years, before getting into trouble. And the majority of people who cut back or quit drinking do so on their own. Many of those people binge drank in their 20s at college parties, at after-work happy hours, or during Sunday afternoon football games, then got a good job, got married, got busy, and lost interest in getting smashed. In the researchers' lingo, they "matured out."

Moreover, alcoholism cannot be blamed for the majority of social ills linked to drinking in this country. Misuse of alcohol costs the nation dearly--$100 billion a year in quantifiable costs, in addition to untold emotional pain. Yet the bulk of these costs are incurred not by alcoholics but by problem drinkers, who are four times more numerous than alcoholics, are more active in society, and usually reject abstinence as a solution. Alcohol figures in 41 percent of traffic crash fatalities and is a factor in 50 percent of homicides, 30 percent of suicides, and 30 percent of accidental deaths. (Last week, a 20-year-old Louisiana State University student drank himself to death during fraternity pledge week; three other students were hospitalized.) Heavy drinking also increases the risk of cancer, heart disease, and stroke, long before people have to worry about cirrhosis of the liver, brain damage, or other skid-row ailments. A 1990 report by the Institute of Medicine, an arm of the National Academy of Sciences, concluded that the harmful consequences of alcohol could not be reduced significantly unless more options were offered to people with only "mild to moderate" alcohol problems.

Threats and firings. Public-health experts recognized the social costs of alcohol abuse long ago and have responded with programs such as free soft drinks for designated drivers and free taxi rides home on New Year's Eve. But because of deeply held beliefs in the American alcohol-treatment community, this kind of pragmatic, public-health-centered approach has rarely been applied to individuals with drinking problems. Europe, Great Britain, and Australia long ago defined problem drinking as a public-health concern and have established controlled-drinking programs to reduce its physical harm and social costs. Forty-three percent of Canadian treatment programs deem moderate drinking acceptable for some clients.

But in the United States, researchers and counselors who have championed--or even tried to investigate--moderation as a treatment strategy have been threatened, sometimes fired. "We've been accused of murder. That we're all in denial. That we're enablers," says Alan Marlatt, a professor of psychology and moderate-drinking proponent who is director of the University of Washington's Addictive Behaviors Research Center.

A big part of the problem is that it's hard to draw a clear line between alcohol dependency and problem drinking. According to a 1996 report by the University of Connecticut's Alcohol Research Center, 20 percent of American adults are problem drinkers, compared with 5 percent who are alcohol dependent. The National Institute on Alcohol Abuse and Alcoholism, using much stricter criteria, puts the numbers at 3 percent alcohol abusers, 1.7 percent alcohol dependents, and 2.7 percent drinkers who exhibit characteristics of both. (Discrepancies in alcohol statistics abound.)

Briefly put, problem drinkers are people who have had problems because of drinking (a DUI arrest, marital discord, showing up late to work). But they usually don't drink steadily and don't go through withdrawal when they stop. By contrast, someone who is alcohol dependent (the medically preferred term for alcoholic) exhibits at least three of the following symptoms: tolerance; withdrawal; an inability to cut down; sacrificing work, family, or social events to drink; devoting a lot of time to finding and consuming alcohol; or persistence in drinking despite related health problems.

Even so, the distinctions leave plenty of diagnostic wiggle room. The medical- and alcohol-treatment communities in the United States have dealt with this ambiguity by applying to all drinkers the advice appropriate for the most severely afflicted: abstinence. Any other strategy, they feel, is too risky. "Every alcoholic would like to drink moderately," says Douglas Talbott, a physician and president of the American Society of Addiction Medicine. "Ninety percent have tried. This just feeds into the denial of the alcoholic."

Moderate-drinking proponents concede that some alcoholics will seize upon controlled drinking as an excuse to avoid abstinence. But they say that they explicitly warn that the strategy is not for alcoholics, only for people with less severe drinking problems; that tests (box, Page 62) can evaluate the intensity of difficulties; and that they regularly refer dependent drinkers to AA. Controlled drinking, says Marc Kern, a Los Angeles psychologist, can "reduce harm by reducing alcohol consumption" and can propel people who fail at moderation into abstinence.

Medical or moral? America's ambivalence toward alcohol is long standing. In the early days of the republic, we were a nation of lushes. Per capita consumption of alcohol was three times today's. The first temperance effort, led by Philadelphia physician Benjamin Rush in the 1780s, prescribed moderation: Rush urged people to switch from rum and gin to the more salubrious beer and wine.

Temperance soon moved from the doctor's office to the church. In 1826, the Rev. Lyman Beecher galvanized the movement with his Six Sermons on Intemperance, which held that alcohol was a poison and that abstinence was the only answer. "This is the way to death!" Beecher said of the drinking life. Ever since, the nature of alcohol abuse has been debated, the arguments often mixing the medical and the moral. Is it a bad habit, a matter of will, or a disease?

The medical model that has dominated alcohol treatment for more than a half century holds that alcohol dependence is an ailment with biological and genetic roots. Recent research suggests there is a genetic predisposition toward alcoholism; identical twins, for instance, are more apt to share a drinking problem than fraternal twins, and adopted children whose birth parents were alcoholics are four times likelier than children adopted from nonalcoholic homes to become alcohol dependent. This disease approach is challenged by behaviorists, the primary advocates of controlled drinking, who say alcohol abuse is a behavior influenced by psychological, cultural, and environmental forces, not just physiology.

Science has yet to come up with enough information to resolve the disease vs. behavior argument. Odds are that alcohol abuse will prove to be a combination of both, the behavioral factors dominating in problem drinkers and biological factors weighing more heavily in people who are physically addicted. But in the meantime, the disease and behavior camps have been warring as if the evidence were absolute. A 1976 Rand report saying that a very small number of alcoholics successfully moderate their drinking was fiercely attacked. "It was like desecrating the altar," says Frederick Glaser, a psychiatrist at East Carolina University School of Medicine in Greenville, N.C., who was a researcher at the time. Mark and Linda Sobell, two psychologists who in the 1970s published similar findings, were accused of faking their results and were hauled up before a congressional committee. The Sobells were later vindicated.

Just say whoa! Though most people in the mainstream treatment community hold tightly to the disease concept of alcoholism, the treatment they offer is based on a combination of folklore and personal experience rather than on science. As Robin Room, a Canadian sociologist who is critical of American alcohol treatment, asks: "What kind of field is it that claims [alcoholism is] a disease, but the treatment is nonmedical?" Enoch Gordis, director of the NIAAA, wrote in 1987 of the nation's $3.8 billion alcohol-treatment effort: "In the case of alcoholism, our whole treatment system . . . is founded on hunch, not evidence, and not on science."

A decade later, quality still varies widely, and anyone seeking solid data on what treatments work best is justified in feeling confused. In a comprehensive 1995 review of the effectiveness of treatment programs, New Mexico psychologists Reid Hester and William Miller concluded that, even for people with severe drinking problems, behavioral treatments (such as brief interventions, contracts governing drinkers' conduct, and coping-skills training) worked significantly better than the fare routinely offered by 12-step programs: group psychotherapy, educational lectures, confrontational counseling, and referral to AA. The gap between those treatments shown to be effective and those that are widely used, they found, "could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of efficacy." But the researchers cautioned that their analysis was a "first approximation," because the quality of the studies surveyed was uneven.

Not for everyone. Analyzing the effectiveness of Alcoholics Anonymous is even more difficult because of the nature of the organization. The self-help group keeps no membership records and does not participate in research. "We're not treatment," says Valerie O., an AA member who answered the phone in the group's New York office. "We just sit there and tell our stories to anyone who asks." Only three trials of AA's effectiveness have been performed, and all three used drunk drivers and others forced to attend the program, which violates the group's creed of voluntary membership. None of these trials rated AA as more effective than alternatives. In a 1990 survey, 65 percent of AA members said they had been sober for a year or more; the survey also found that the majority of people who start AA drop out within a year. When AA works, it works extraordinarily well: The testimonies of lives saved by AA are legion. But it's not for everyone.

Because alcohol treatment is so unscientific, some of the most basic and effective standards of care are ignored. Instead of adhering to the stepped-care protocol employed in other areas of medicine--where the least invasive treatment is used first--alcohol treatment starts with its most drastic remedy: lifetime abstinence, meetings, and, until recently, a 28-day residential stay in a substance-abuse clinic. As a result, many people who need help don't seek it. Others try AA but feel it doesn't meet their needs.

That's what happened to Moderation Management founder Audrey Kishline. In her 20s, she was drinking five or six glasses of wine a night, drinking alone, drinking and driving. Diagnosed as an alcoholic, she was sent to detoxification, to residential treatment, and to AA. But Kishline didn't feel she had been alcohol dependent: She had no withdrawal symptoms, and she found it easy to abstain for months. She started researching alcohol treatment, and was outraged to find that alternatives common in Europe were never even mentioned here. "The public's not getting the full story," Kishline says. Now 40, married and raising two children, she occasionally has a glass of wine with dinner. Had she initially been offered less drastic treatment, Kishline believes, she would have reached this point of temperance years sooner.

Other veterans of the treatment system object to AA's explicitly spiritual focus, a reliance on God or a "higher power" that permeates many 12-step programs as well. Last year, the New York State Court of Appeals ruled that prisoners are constitutionally protected from being forced to participate in AA because of its religious orientation. Similar rulings have been made in California and other states. And several abstinence-based self-help groups, including Rational Recovery, Secular Organizations for Sobriety, and SMART Recovery Self-Help Network, have been founded by people critical either of AA's spiritual focus or of the belief that they are powerless against alcohol.

Changing times. Gradually, however, the alcohol-treatment portfolio is diversifying. After expanding wildly in the 1970s and 1980s, residential 12-step programs are falling on hard times: Insurers and employers, pressed by rising health care costs, find little benefit to justify the programs' considerable expense and are seeking cheaper, less intensive alternatives. Alcohol-treatment research is moving slowly toward a more scientific, empirically based approach. And a national trend away from heavy drinking--alcohol consumption has fallen by 15 percent since 1980, paralleling declines in smoking and illegal drug use--makes it, oddly enough, more acceptable to treat those with only mild alcohol problems, not just Days of Wine and Roses-style lushes.

Wisconsin offers a sense of what the future may hold. It is a big drinking state; 25 percent of its residents say they binge drink. "Every little town has a church and a bar," says Michael Fleming, a University of Wisconsin Medical School family physician. "Most of the patients in my practice drinking six drinks a day are not alcoholics. But if we can get them to cut down from six drinks to two, from a public-health perspective you've made a huge impact."

In April, Fleming published the first large U.S. study of brief interventions for problem drinkers in the Journal of the American Medical Association. The study, patterned on research over the past 20 years in Great Britain and Sweden, selected 774 problem drinkers from patients at 17 Wisconsin clinics. Half the patients met for two 15-minute sessions, one month apart, with their physicians, discussed their current health behavior and the effects of alcohol, and signed a prescriptionlike drinking contract. A year later, the men had reduced their alcohol use by 14 percent; the women, by 30 percent. (Women are usually more successful than men at moderating.) The control group also reduced its drinking, but the brief intervention group was twice as likely to reduce it by 20 percent or more.

Other promising research is coming from Seattle, where University of Washington psychologist Marlatt is working with a notoriously immoderate population--college students. For the past seven years, he has followed 350 students who were identified while still in high school as high-risk drinkers.

A year after half the students were given a one-hour, one-on-one educational session in their freshman year, 80 percent had reduced binge drinking substantially. Those who didn't were given more education and counseling, with the intensity escalating each year. "It's a harm-reduction approach," Marlatt says, using a phrase more often applied to needle exchanges and other drug-abuse programs. "With young people, if you only offer abstinence, they're not going to sign up."

Another brief intervention program, offered to adults by the University of Michigan Medical Center's DrinkWise program, is patterned on one developed at Toronto's Addiction Research Foundation. DrinkWise offers four one-hour educational counseling sessions, in person or by phone, with three- and nine-month follow-up calls, for $495. East Carolina University will launch its own DrinkWise program later this year.

Many people enter alcohol treatment not by choice but by court order for drunk driving and other offenses. They, too, are beginning to gain a few more options. Last year California ruled that Los Angeles County does not have to require offenders to attend an abstinence-based self-help group, making room for Moderation Management as a legal alternative to AA.

But these groups are still gnats compared to the elephant of AA. Moderation Management has just 50 volunteer-run groups; AA has an estimated 1.2 million members in the nation. Only 8 to 10 people show up for the weekly Manhattan meeting of MM, which Elisa DeCarlo runs. "We're like booze revolutionaries," she says cheerfully.

There's reason to hope today's revolutionaries will get a more open hearing than their predecessors: The NIAAA, along with other federal agencies, is increasing funding for different alcohol treatments. Someday, perhaps, controlled-drinking programs will be as commonplace as Weight Watchers and Smokenders, and problem drinking will be recognized as a $100 billion public-health problem requiring solutions as varied and complex as our long, tempestuous relationship with alcohol.

Cutting back
These organizations and people offer help to those who want to reduce their drinking.

DrinkWise. Brief intervention in person or by phone. At the University of Michigan Medical Center, 800-222-5145; [http://www.med.umich.edu/drinkwise]. At East Carolina University Medical School, 888-816-2736; E-mail: tedmondson@brody.med.ecu.edu

Moderation Management. Self-help group with meetings, an Internet discussion group, and Audrey Kishline's book, Moderate Drinking (Crown, $14): 612-512-1484; [http://comnet.org/mm/]

Counselors. New Mexico psychologist Reid Hester's Web page [http://www.lobo.net/rhester/software.htm] lists behavioral counselors and links to other resources.

PHOTO (COLOR): Denver. Fans buy beer at a Colorado Rockies game. Alcohol plays a role in 41 percent of traffic crash fatalities and 50 percent of homicides.

PHOTO (COLOR): Pittsburgh. A homeless woman who panhandles for a living drinks a beer and prepares for sleep under a city overpass.

PHOTO (COLOR): Boulder, Colo. Relaxation and gourmet microbrews lure patrons to the West End Tavern.

PHOTO (COLOR): Hardin, Mont. A man walks near the Four Aces Bar & Lounge. Hardin is the nearest place where people who live on the Crow Reservation can buy alcohol.

PHOTO (COLOR): Penowa, Pa. Happy hour starts early at Jack's State Line Inn. Between 44 percent and 51 percent of Americans drink regularly.

PHOTO (COLOR): Pittsburgh. Alcohol laces most social occasions. Below, recent college grads play Trivial Pursuit in a south side apartment.

PHOTO (COLOR): McLean, Va. Thirty-two million Americans say they binge drink at least once a month.

PHOTO (COLOR): Miami. Alcohol consumption has fallen by 15 percent since 1980. But beer is still