

Regular article

Reduced-risk drinking as a treatment goal: what clinicians need to know

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Abstract

Reduced-risk drinking as a treatment goal for clients with alcohol problems has received limited acceptance in the United States. The majority of literature addressing reduced-risk drinking has focused on debates between proponents of traditional abstinence treatment and those supporting nonabstinence treatment. Proportionately little attention has been given to objective consideration of the potential advantages of integrating both abstinence and nonabstinence goals as part of a comprehensive continuum of treatment for clients with alcohol problems. Further, there is a lack of guidelines available to assist clinicians in treating and supporting clients with nonabstinence goals. The purpose of this article is to review the potential advantages of reduced-risk drinking for clients with alcohol problems and to forward strategies designed to assist clinicians in safely treating clients who wish to reduce rather than abstain from drinking alcohol. Current gaps in the literature and implications for future research are identified. © 2002 Elsevier Science Inc. All rights reserved.

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1. Introduction

Reduced-risk drinking, also commonly referred to as moderated drinking, asymptomatic drinking, and controlled drinking, refers to the ability of an individual who has previously exhibited out-of-control drinking to return to a decreased, or more controlled pattern of alcohol consumption (Denzin, 1993). Reduced-risk drinking is one example of a public health approach known as harm reduction. The aim of harm reduction is to reduce the negative consequences of substance use for both the client and the community by encouraging any behavioral change that reduces harm or the risk of harm (Tucker, 1999). Other examples of harm reduction include: (a) AIDS prevention interventions such as safe sex education and needle exchange programs; (b) methadone maintenance for opiate dependence; and (c) nicotine replacement to reduce tobacco use (Marlatt, Somers, & Tapert, 1993).

Reduced-risk drinking is an acceptable treatment goal in Europe, parts of Australia, and to a lesser extent, Canada (Brochu, 1990; Dawe & Richmond, 1997; Rosenberg,

Devine, & Rothrock, 1996). This approach has been less accepted in the United States where abstinence is considered to be the desired, and often the only treatment goal for clients with alcohol problems. Within the addictions literature, endorsement of any amount of drinking for alcohol abusing clients has historically been subject to heated and often emotionally laden debates. The crux of these debates is a strong allegiance to the disease model of alcoholism and the belief that any alcohol consumption will cause an inevitable loss of control over one's alcohol use (Jellinek, 1946; 1952; 1960; Miller & Toft, 1990). Further, there appears to be an erroneous assumption that the implementation of a non-abstinence based approach such as reduced-risk drinking renders abstinence based approaches less effective

Because discourse has focused largely on polemics, limited attention has been given to studies evaluating the effectiveness of reduced-risk drinking treatment approaches or the potential feasibility of integrating both abstinence and nonabstinence based approaches into a comprehensive continuum of services for clients with alcohol problems. Because treatment agencies and facilities primarily endorse abstinence as the only acceptable treatment goal, clinicians are not supported or socialized to provide nonabstinence based treatment for clients. Further, there is a lack of empirical guidelines regarding how to safely implement a reduced-risk drinking goal with clients. The purpose of this

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article is to review the potential advantages of reduced-risk drinking for clients with alcohol problems and to forward information and strategies designed to assist clinicians in safely treating clients who wish to reduce, rather than completely abstain from drinking alcohol. Empirical findings from studies on reduced-risk drinking will be reviewed. Current gaps in the literature, and implications for further research will be identified.

2. Abstinence vs. nonabstinence: a historical overview

Connors (1993) noted that as early as the 1940s, follow-up studies of clients in treatment for alcohol problems identified subgroups of subjects who were seemingly able to resume drinking following a period of abstinence (Armor, Polich, & Stambul, 1976; Armor, Stambul & Polich, 1977; Connors, 1993; Davies, 1962; Miller, 1983; Polich, Armor, & Braiker, 1981). These early studies were not specifically designed to evaluate the effectiveness of reduced-risk drinking. Rather, findings reported on individuals, or small subgroups of subjects who after receiving abstinence based treatment, were noted at follow-up to be drinking reduced amounts of alcohol with no apparent difficulty.

These studies generated a great deal of controversy within the addictions field. Two of the most frequently cited and contested studies include Davies' (1962) study of men treated for alcohol addiction and The Rand Report (Armor et al., 1976; Polich et al., 1981). In the Davies (1962) study, 7 out of 93 alcohol dependent subjects were noted to be drinking at reduced amounts at 7–11 year follow-up. This finding was subsequently challenged in a 29–43 year follow-up study of the same 7 subjects (Edwards, 1985a; 1985b), in which only 1 of the 7 men was noted to be maintaining reduced-risk drinking.

A decade later, The Rand Report (Armor et al., 1976) presented longitudinal data from a national sample of treated alcohol dependent clients. At the 18-month follow-up, some subjects were noted to be engaging in reduced-risk drinking. A subsequent report estimated that 20% of subjects were engaging in problem-free, reduced-risk drinking (Polich et al., 1981). Findings ignited a great deal of controversy and challenges to the validity of the findings and the overall study methodology (Adinolfi & DiDario, 1977; Blume, 1977; Emrick & Stilson, 1977). Further, fears abounded that these findings would encourage all individuals with alcohol problems to either resume drinking or continue to drink. Addictions researchers and clinicians subsequently divided into abstinence vs. nonabstinence camps; a dichotomy that to some extent, continues to the present. Consequently, findings from studies designed to evaluate the effectiveness of treatment approaches specifically designed to assist clients in reducing their alcohol use have received comparatively less attention (Foy, Nunn, & Rychtarik, 1984).

3. Empirical support for reduced-risk drinking as a treatment goal

Over the past three decades, a number of studies have examined the effectiveness of various treatment approaches designed to assist clients in reducing their alcohol use. Early studies were largely behavioral and conducted in controlled laboratory settings using subjects with a continuum of alcohol problems ranging from problem drinking to severe alcohol dependence (Baker, Udin, & Vogler, 1975; Caddy & Lovibond, 1976; Cohen, Liebson, Faillace, & Allen, 1971; Lovibond & Caddy, 1970; Miller, 1978; Mills, Sobell, & Schaefer, 1971; Sobell & Sobell, 1973; Vogler, Compton, & Weissbach, 1975). These studies did not compare subjects with abstinent and nonabstinent treatment goals. Rather, they examined the effectiveness of various combinations of treatments in shaping social drinking behaviors as an avoidance response to aversive stimuli. Subjects were assigned to experimental and control conditions and administered various treatments including: (a) self-monitoring instruction for blood alcohol concentration (BAC); (b) supportive therapy and counseling; (c) alcohol education; (d) aversive conditioning consisting of electric fingertip shock; and (e) videotaped self-confrontation.

Overall findings from these studies included the following: (a) subjects were able to learn how to estimate their BAC after one training session (Lovibond & Caddy, 1970; Miller, 1978); (b) small subgroups of subjects with chronic alcohol dependence were able to decrease their alcohol use during the study (Baker et al., 1975; Cohen et al., 1971; Mills et al., 1971), or maintain reduced-risk drinking at follow-up points up to 1 year posttreatment (Caddy & Lovibond, 1976; Lovibond & Caddy, 1970; Sobell & Sobell, 1973; Vogler et al., 1975); (c) some subjects classified as problem drinkers were able to engage in reduced-risk drinking at 1 year follow-up (Miller, 1978); and (d) costly and laborious programs were not necessary to assist problem drinkers in reducing their alcohol consumption (Miller, 1978).

A number of limitations to these studies are addressed in the literature including: (a) small, nonrandomized samples of predominantly male subjects; (b) subject attrition at follow-up; and (c) short follow-up times. Further, three of the studies (Baker et al., 1975; Sobell & Sobell, 1973; Vogler et al., 1975) recruited subjects at different times, but from the same inpatient facility, thus raising further issues regarding the external validity of the findings (Foy et al., 1984). However, study findings provided support for reduced-risk drinking as a feasible option for some clients with a continuum of alcohol problems.

Likewise, in studies specific to reduced-risk drinking, a consistent finding is that small subgroups of subjects across the continuum of alcohol problem severity have been able to maintain problem free drinking over time (Alden, 1988; Booth, Dale, & Ansari, 1984; Booth, Dale, Slade, & Dewey, 1992; Foy et al., 1984; Hodgins, Leigh, Milne, & Gerrish,

1997; Miller & Joyce, 1979; Miller, Leckman, Delaney, & Tinkom, 1992; Orford & Keddie, 1986; Sanchez-Craig, Annis, Bornet, & MacDonald, 1984; Sitharthan & Kavanagh, 1990; Stimmel et al., 1983). For example in one study of 70 early-stage problem drinkers assigned to either an abstinence or reduced drinking goal, alcohol consumption decreased in both groups per day (4 drinks vs. 10 drinks), and per week (3 days vs. 5.5 days) at 6 months, with the trend continuing at 2-year follow-up (Sanchez-Craig et al., 1984). In another study, four cohorts of subjects ($N = 99$) were followed at 3.5, 5, 7, and 8 years (Miller et al., 1992). Miller et al. (1992) noted that 14 subjects met conservative criteria for asymptomatic drinking (moderate consumption, no evidence of dependence or negative consequences). Of these, 10 were diagnosed as alcohol dependent. In other studies, subgroups of alcohol dependent subjects have maintained reduced drinking at one to 2-year follow-up (Booth et al., 1992; Stimmel et al., 1983).

Studies comparing the effectiveness of abstinence vs. nonabstinence treatment goals have yielded varying results. No significant differences have been noted between those subjects who chose or were assigned a reduced drinking treatment goal and their abstinent counterparts. (Booth et al., 1984; Booth et al., 1992; Orford & Keddie, 1986; Sanchez-Craig et al., 1984; Stimmel et al., 1983). Further, in at least two studies, subjects in the reduced-drinking group fared worse than subjects in the abstinent group, as measured by fewer abstinent days and more abusive drinking days (Foy et al., 1984; Hodgins et al., 1997). One reason for this may have been related to the severity of the subjects' pretreatment alcohol dependence, but empirical findings supporting this have been mixed. Foy et al., (1984) noted that subjects classified as highly dependent and assigned to a reduced drinking goal were 75% more likely to abuse alcohol; a finding not noted in the abstinence group. In contrast, Orford and Keddie (1986) found no support for a linkage between severe alcohol dependence and difficulties establishing reduced-risk drinking.

There is indication that clients do better when allowed to choose vs. being assigned a treatment goal (Booth et al., 1984; Hodgins et al., 1997; Miller et al., 1992; Sanchez-Craig et al., 1984; Sanchez-Craig & Lei, 1986). Sanchez-Craig et al. (1984) questioned whether the random assignment of subjects to either an abstinent or moderation goal contributed to the nonsignificant findings in their study. In a subsequent analysis of these findings, Sanchez-Craig and Lei (1986) noted that with heavy drinkers, imposition of an abstinence goal was not effective in promoting abstinence or reduced-risk drinking. Further, there is evidence that subjects who choose to abstain often revert to reduced-risk drinking (Sanchez-Craig et al., 1984), while subjects who initially choose a goal of reduced-risk drinking transition to complete abstinence (Hodgins et al., 1997).

Compared to those who choose to abstain, subjects who choose a reduced-risk drinking goal tend to: (a) be younger; (b) have lower levels of alcohol consumption

and a less severe pretreatment drinking history; (c) be less likely to have a family history of alcohol problems; (d) be less likely to have attended Alcoholics Anonymous (AA); and (e) be more likely to reject a label of "alcohol problems" (Booth et al., 1984; Cannon, Baker, & Ward, 1977; Hodgins et al., 1997; Miller & Joyce, 1979; Miller et al., 1992; Pachman, Foy, & Van Erd, 1978). Cannon et al. (1977) further identified a group of alcohol dependent subjects likely to choose a reduced-risk drinking goal due to a desire to continue drinking, a lack of confidence in the ability to abstain, or the need to prove that they are not alcohol dependent.

It should be noted that the studies reviewed have been limited by a number of factors. Sample sizes were small, homogenous and primarily male, ranging from 37 subjects (Booth et al., 1984) to 140 subjects (Miller et al., 1992). Selection bias due to nonrandomization of the sample and in many cases, nonrandom group assignment was also a limitation. Attrition rates at follow-up were high, ranging from 26% (Hodgins et al., 1997) to as high as 42% (Stimmel et al., 1983). While this is not a surprising finding in this population, high attrition does raise questions regarding the potential differences between those subjects who completed the study, and those lost over time. Self-report was the primary means of measuring alcohol consumption. While a number of studies attempted to address this limitation by including collateral reports, family members and friends could not always be located (Alden, 1988; Booth et al., 1984; Foy et al., 1984; Miller et al., 1992; Orford & Keddie, 1986). Another limitation was the follow-up durations. Most were relatively short, averaging 1–2 years. There is evidence that the assessment of client status short-term may be predictive of long-term success or failure, thus supporting short follow-up points as indicative of long-term success (Miller, 1978; Sitharthan & Kavanagh, 1990). However, varying follow-up times make comparisons of study findings difficult.

In light of these limitations, findings must be interpreted cautiously. However, in summary, there is some empirical support for the following: (a) reduced-risk drinking is a viable option for some problem and dependent drinkers; (b) abstinence and nonabstinence based treatments appear to be equally effective. One approach is not superior to, or safer than the other; (c) clients with moderate to severe alcohol dependence may do better abstaining vs. reducing alcohol consumption; and (d) allowing the client to choose a goal may promote a successful outcome.

4. Rationales supporting inclusion of reduced-risk drinking as a treatment goal

An estimated 14 million American adults abuse or are dependent on alcohol (Grant et al., 1994) at an annual cost of approximately US\$184.6 billion (U. S. Department of Health and Human Services, 2000). These costs are inflicted

not only on the drinker, but on all of society. The problem drinker and his/her significant others face any number of physical, emotional, financial and legal consequences from problem drinking. The economic burden of substance abuse falls largely on the population that does not abuse drugs via private and public health insurance; life insurance; tax payments; pensions; social welfare insurance; drug and alcohol-related crimes and trauma; and government services such as highway safety.

Clearly, the health-related, social and financial costs of problem drinking emphasize the need for a number of strategies and treatment modalities designed to: (a) engage and maintain clients in treatment; (b) safely and efficaciously treat a continuum of alcohol problems ranging from alcohol abuse to alcohol dependence; and (c) provide the most appropriate services at the lowest costs. However, the majority of clients with alcohol problems do not use existing treatment services (Sobell & Sobell, 1995). Whether this is a reflection of the natural history of addiction, personal characteristics of the client, or the availability and accessibility of treatment is not known. What is known is that within the present health care system, a number of individuals, and particularly those with early drinking problems, are not currently involved in treatment.

Harm reduction techniques such as reduced-risk drinking offer an alternative to the traditional abstinence-based treatment dominant in this country. A number of arguments support reduced-risk drinking as a viable treatment option worthy of careful consideration. For simplicity, these arguments can be summarized as: (a) the lack of empirical findings that support the disease perspective of alcoholism and particularly, the assumption that all dependent drinkers experience loss of control; and (b) the importance of offering a variety of treatment options to clients since no single approach is consistently better for all individuals. Arguments included in the former category are well documented in the literature (Donovan & Chaney, 1985; Marlatt, 1985; Marlatt & Gordon, 1985; Miller & Caddy, 1977; Pattison, Sobell, & Sobell, 1977; Peele, 1992; Peele & Brodsky, 1991) and will not be reviewed here. However, comparatively less attention has been given to the advantages of offering clients both nonabstinence and abstinence treatment options.

5. Advantages of offering both abstinence and nonabstinence treatment goals

The vast majority of treatment agencies in this country promote abstinence as the only acceptable treatment goal for clients with alcohol problems (Rosenberg & Davis, 1994; Searles, 1993; Toriello, Hewes, & Koch, 1997). However, as previously noted, there is empirical support that many clients who desire help are unwilling to accept the “alcoholic” or even “problem drinker” labels and the accom-

panying expectations of abstinence (Miller & Caddy, 1977; Miller et al., 1992; Sanchez-Craig & Lei, 1986). Consequently, for those clients who do seek treatment, goals that do not include abstinence may be dismissed as inappropriate and not considered in the client’s plan of care. Such clients may be seen as being in “denial” and may be dismissed, or as Heather (1995) pointed out, advised to “. . . go away and come back again only after they had ‘wised up’ to the nature of their disease or plunged even further towards rock bottom” (p. 1161). These clients may subsequently slip through the cracks, disillusioned by the system from which they sought help.

Clients are more likely to remain engaged in treatment when they are presented with more than one treatment option and are given a degree of responsibility and control over treatment decisions. Further, this process often results in overall lower alcohol consumption for clients who do reject total abstinence. For example, clients who are given the opportunity to attempt reduced-risk drinking but ultimately relapse, are often more willing to then accept an abstinence goal. One longitudinal study followed a treatment sample of 106 subjects diagnosed with chronic alcohol dependence (Hodgins et al., 1997). Subjects were given the choice of abstinence or moderate drinking treatment goals. Forty-six percent of the subjects ($n = 49$) initially chose an abstinence goal and 44% ($n = 47$) of the sample chose moderate drinking as a treatment goal. After 4 weeks of treatment, 89% ($n = 42$) of the subjects in the abstinence group retained their goal compared to 51% ($n = 24$) of the moderate drinkers. While data from 3 subjects was missing, Hodgins et al. (1997) noted that over the first 4 weeks of treatment, subjects were most likely to move from a moderate goal to an abstinence goal.

Conversely, clients who initially abstain from alcohol may revert to reduced-risk drinking. In another longitudinal study, 70 subjects classified as early-stage problem drinkers were randomly assigned to a treatment goal of either abstinence or moderate drinking (Sanchez-Craig et al., 1984). At a 2-year follow-up, both groups had maintained a decrease in drinking from an average of 51 drinks per week per subject, to 13 drinks per week per subject, with no significant differences between the groups. Sanchez-Craig et al., (1984) noted that for the majority of this sample, moderate drinking was regarded as a more acceptable goal. Further, the majority of clients assigned to the abstinence group had independently reverted to moderate drinking over the period of the study.

In summary, offering both abstinence and nonabstinence treatment goals to clients demonstrates a willingness to work with clients rather than to simply impose standard goals upon the client. This may increase the chances the client who may have otherwise rejected a goal of abstinence will remain involved in treatment. Further, by remaining connected in treatment, clients likely stand a greater chance of being able to reduce or cease drinking over time.

6. Treatment guidelines for clinicians

Working with clients with nonabstinence goals raises important issues related to the safety of endorsing any amount of drinking by clients with alcohol problems. However, with the exception of a few articles (Miller & Caddy, 1977; Miller & Page, 1991; Sanchez-Craig, Wilkinson, & Davilla, 1995; Spivak & Sanchez-Craig, 1994) and books (Heather & Robertson, 1981), there is a lack of attention to the establishment of guidelines designed to assist clinicians in the implementation of nonabstinence based goals appropriate for clients with a continuum of drinking problems.

Clinicians and treatment facilities may be reluctant to support nonabstinence due to the lack of information available, lack of support from peers and superiors, and fears of endorsing abusive drinking with clients. If clinicians are to comfortably support nonabstinence goals, they must be able to do so without fears of jeopardizing their jobs and endorsing harmful practices with vulnerable clients. The first issue is one that requires a philosophical shift in the majority of treatment agencies in this country. Simply put, clinicians cannot be expected to support non-abstinent clients if they are affiliated with agencies that only endorse abstinence. The second issue, which is addressed here, requires further exploration, clarification and consensus regarding safe guidelines for reduced-risk drinking. It is not ethical, sufficient, or efficacious to simply encourage clinicians to “tell” clients to reduce their alcohol consumption. Rather, there must be a specific, written treatment contract between the clinician and the client based on established guidelines for reduced-risk drinking. These guidelines should include: (a) clear, unambiguous parameters for reduced-risk drinking; (b) consensus regarding what constitutes a standard drink; (c) a clear contingency plan; and (d) strategies for negotiating treatment goals with clients.

6.1. Establishing parameters for reduced-risk drinking

Parameters for reduced-risk drinking can be found in the literature. For example, the U. S. Department of Agriculture and U. S. Department of Health and Human Services (1990) jointly define moderate drinking as a maximum of 1 drink a day for women and 2 drinks a day for men, with a standard drink consisting of 12 ounces of beer, 5 ounces of wine or 1.5 ounces of 80-proof distilled spirits. In 1995, the National Institute of Alcohol Abuse and Alcoholism [NIAAA] published a guide for physicians working with clients with alcohol problems. Clinical recommendations for moderate drinking were the same as those forwarded by the USDA and USDHHS (1990) with the addition of a specification of 1 drink per day for both men and women over the age of 65. More recently, Sanchez-Craig et al. (1995) analyzed the findings from three separate studies comprised of 144 male and

91 female problem drinkers in order to specifically validate established guidelines for reduced-risk drinking. Based on this analysis, Sanchez-Craig et al. (1995) forwarded a slightly more liberal recommendation of no more than 3 drinks per day and 12 drinks per week for women and 4 drinks per day to a maximum of 16 drinks per week for men.

While existing parameters vary, they do provide empirically supported upper and lower limits for moderate reduced-risk drinking. Based on the current literature, and particularly the findings from the Sanchez-Craig et al. (1995) study, the following guidelines are forwarded: (a) three drinks, or at maximum, 4 drinks on any day and no more than 16 drinks per week for men; (b) two drinks, or at maximum, 3 drinks on any day, and no more than 12 drinks per week for women; (c) one drink, or at maximum 2 drinks per day and no more than 8 drinks per week for anyone over the age of 65; (d) avoid having more than 1 drink in an hour; (e) avoid drinking in a pattern such as with the same people, or at the same time or place; (f) avoid drinking as a means of coping with problems; (g) do not drink anytime before or while driving or operating hazardous machinery; (h) do not drink at all during pregnancy or while breastfeeding.

Other guidelines can also be incorporated into the plan such as instructing the client to not drink 2 days in a row. Clients should also be instructed to maintain a diary recording: (a) what they drink; (b) when they drink; (c) how much they have to drink; and (d) the context in which they are taking the drink. This provides a powerful means of assisting the client in maintaining awareness of when they take a drink, how much they are drinking, and any existing patterns and “triggers” to alcohol consumption (Sanchez-Craig et al., 1995).

6.2. Standardization of a drink

A different, but related issue that must be addressed here is the lack of a universally accepted definition of the alcohol content in what is considered to be a standard drink (Dufour, 1999). In this country, a standard drink is considered to be: (a) 12 ounces of beer; (b) 5 ounces of wine; or (c) 1.5 ounces of 80 proof distilled spirits (National Institute on Alcohol Abuse and Alcoholism, 1995). However, as Dufour (1999) pointed out, “. . .the size of one drink is entirely up to the person pouring it and may vary from occasion to occasion” (p. 6). For this reason, it is not enough to specify “a” drink as this is subject to varying interpretations. Clients will need specific, written guidelines regarding how much beer, wine, or spirits constitute one drink. Further, clients will need educational and even role-play sessions on: (a) how to order drinks prepared by other people; (b) the need to read product labels; and (c) awareness and avoidance of cooking sauces, mouthwashes and other products that contain alcohol.

6.3. *Establishing a contingency plan*

Once the parameters of reduced-risk drinking are established, individualized contingency plans must be included in the written treatment contract. For example, clients need to have access to resources in the case of an emergency or unexpected circumstance. If the clinician is off the clock, is someone else on-call? Does the client have an emergency crisis number available? Does the client have a specific coping plan in the event that he/she drinks more than the allotted drinks per day or per week? Who does the client identify as someone he/she can go to when stressed? Does the client's family and/or significant others support a treatment goal of reduced-risk drinking? Does the client know the signs and symptoms of withdrawal and have access to an emergency phone number and hospital in the event that withdrawal symptoms occur? What if the client is unexpectedly hospitalized or incarcerated? Will the client be comfortable explaining his/her treatment to other health care providers so that measures can be taken to minimize any withdrawal symptoms that may occur?

Attendance at support groups presents another issue that must be addressed. Twelve-step groups such as AA subscribe to the disease model of alcohol dependence and the belief that all individuals with alcohol dependence experience loss of control when they take even one drink. Consequently, alcohol use is not endorsed within the fellowship. If the client has attended or plans on attending AA or other 12-step groups, there must be some dialogue between the clinician and the client as to how or if the client will find the support he/she needs participating in a group that does not support reduced-risk drinking. The availability and feasibility of other options should be discussed.

It is crucial clinicians realize that negotiating parameters for reduced-risk drinking is only a small part of the overall planning. Assisting the client in anticipating as many unforeseen events as possible, and rallying support systems the client can access are extremely important components of treatment. Anticipating and planning for such events and establishing a realistic coping plan will decrease the chances of the client exceeding the maximum drink allotment, or having a serious side effect.

6.4. *Strategies for working with clients with nonabstinence treatment goals*

Another issue pertains to specific strategies that can assist clinicians in negotiating particular treatment goals with their clients. Specifically, this involves addressing the appropriateness of a nonabstinence goal for a particular client and differences in opinion between the clinician and client regarding whether the goal of treatment should be abstinence or nonabstinence. It has been established in the literature that clients who abuse or are mildly dependent on alcohol have been thought to be most appropriate for non-

abstinence based treatment (Connors, 1993; Dawe & Richmond, 1997; Foy et al., 1984; Sobell & Sobell, 1995). However, there is some empirical support that some clients with severe dependence can sometimes resume drinking reduced amounts of alcohol (Armor et al., 1977; Davies, 1962; Miller et al., 1992; Sanchez-Craig et al., 1984). While the client's drinking history is an important consideration, it should not be the sole determining factor regarding whether the best goal of treatment is abstinence or reduced-risk drinking. The clinician must also consider the increased likelihood that the client will continue treatment if he/she is allowed to choose a goal, vs. having the goal imposed by the clinician.

There are certain contraindications to reduced-risk drinking including: (a) the client's unwillingness to set a nonabstinence goal; (b) the presence of medical or psychological conditions that may be exacerbated by continued alcohol ingestion; (c) use of medications that are considered dangerous when combined with alcohol; (d) a history of repeated, failed attempts at reduced-risk drinking; (e) pregnancy; (f) breastfeeding; and (g) a history of severe alcohol withdrawal symptoms (Miller & Caddy, 1977; Miller & Page, 1991). For clients with one or more of these contraindications, abstinence is the preferred treatment goal. However, the clinician may be faced with a number of dilemmas. For example, how does one treat the client who presents with one or more of the above contraindications, yet refuses to abstain? In the spirit of harm reduction, do you support a treatment goal of reduced-risk drinking despite the contraindications? Do you refer the client elsewhere? Do you encourage him/her to return when they are willing to consider abstinence, thus increasing the risk that the client will continue to abuse alcohol?

When faced with such challenges it is essential that the clinician remain objective. This is not the time for the clinician to immediately voice his/her expert opinion, nor is it the time to dismiss the client as being not serious about treatment. Rather, this is the time to dialogue with the client about the client's reluctance. This should occur regardless of how "well known" the client may be to the clinician. What are the client's reasons for not wanting to abstain? Is the client unwilling to see him/herself as having an alcohol problem? Does the client lack confidence about his/her ability to be able to abstain due to unsuccessful past attempts? Is the client simply unwilling, at this time, to relinquish alcohol? Through neutrality and thoughtful questioning, the clinician can gain a greater understanding of what the client's issues and concerns are. This in turn will assist the clinician in choosing a particular strategy.

There are some strategies for working with challenging clients who refuse abstinence. Miller and Page (1991) suggest the clinician contract with the client to try abstinence for 3 months with the understanding he/she can resume the previous drinking pattern after this period of time. They further note that presenting this trial as a positive challenge can serve as a motivating factor for the client. Of

course, the desired result is that in the process of this trial period, the client may opt to continue abstinence, or resume drinking at decreased levels than previously.

Another approach is to offer the client a trial period of reduced-risk drinking with the understanding that if at any time the client exceeds the contracted drinking parameters, he/she will then consider abstinence (Miller & Page, 1991). Both approaches require a written, therapeutic contract between the clinician and client including length of time, clinic contacts, parameters regarding how many drinks constitutes reduced-risk drinking, and a clear contingency plan. In all cases, regardless of what decision is made, the number of times the client has been previously seen, or whether or not the client is referred elsewhere, it is crucial that the clinician assist the client in making an informed choice about his/her treatment. This entails ensuring the client fully understands the contraindications to reduced-risk drinking, the risks of continuing to drink, and the rationales supporting abstinence.

7. Future recommendations

Terms such as “controlled drinking” “moderate drinking” and “reduced-risk drinking” are typically used interchangeably, but may be defined very differently in the literature (Connors, 1993; Dufour, 1999). Consequently, this creates ambiguity regarding what one really means. For example, research addressing the health benefits and risks of moderate drinking in a sample of individuals with no known alcohol problems is very different from studies of moderate drinking with clients having alcohol problems. While both types of studies have greatly different purposes and samples, similar terminology is used, creating confusion. When using these terms it is important that one clearly defines and quantifies the chosen term.

While there has been an increase in the number of studies addressing reduced-risk drinking, there remains a need for continued research, especially studies that compare clients with abstinence and nonabstinence treatment goals. There is particular need for longitudinal, clinical studies in which matched clients with abstinence and nonabstinence treatment goals receive the same formal treatment. Following clients over time should provide rich data regarding alcohol consumption over time. Clients could also be matched and divided into four groups including: (a) abstinence choosers; (b) reduced-risk drinking choosers; (c) abstinence assigned; and (d) reduced-risk drinking assigned. Further, via continued research, the parameters of reduced-risk drinking may be modified and expanded for particular subgroups of clients.

Empirical findings matching particular goals with client characteristics will provide valuable information for clinicians in guiding and supporting clients. In addition, other variables such as the attractiveness of particular approaches to clients (Sobell & Sobell, 1995), cultural variables that

may impact treatment (Sanchez-Craig et al., 1995), the various paths of remission taken by clients with drinking problems (Connors, 1993) and the relationship between the severity of an alcohol problem and remission from abstinence and nonabstinence based treatment require further exploration.

In conclusion, within the current health care environment, there is a clear need for interventions that are cost-effective, efficacious and attractive to clients. This warrants reexamination and reconsideration of alternative treatment strategies that can be implemented across a variety of settings and clients. Reduced-risk drinking can be a viable option for some clients with a continuum of drinking problems, and is presented as a complementary approach to abstinence-based treatment.

However, in order to support clients with reduced-risk drinking goals, clinicians need to be supported by their treatment agencies and trained regarding how to safely implement this approach. To these ends, this article has described a number of clinical considerations and training issues pertaining to the implementation of a reduced-risk drinking goals.

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