

RETHINKING DRINKING



Rethinking Drinking:

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

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1



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2

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

3



IMPORTANT: Format of Today's Webinar

- ◆ I will pause my lecture every 20-30 minutes for Q&A. I will not stop in between to take questions or comments.
- ◆ Please do not post your questions in advance– I will not have time to read them while lecturing
- ◆ If you want to ask a question during the Q&A period simply click the "raise your hand" icon on your screen to be placed on the list
- ◆ When it's your turn to ask a question during the Q&A period, I will unmute your microphone so everyone can hear you. Please make your questions brief and to the point. We do not have time for extended comments.
- ◆ I will try to address as many questions as time permits during each Q&A period and will gladly stay for 10-15 minutes at the end of the webinar for further discussion, if requested,
- ◆ If you wish to contact me after the webinar, my email address is awashton@gmail.com, website www.thewashtongroup.com.

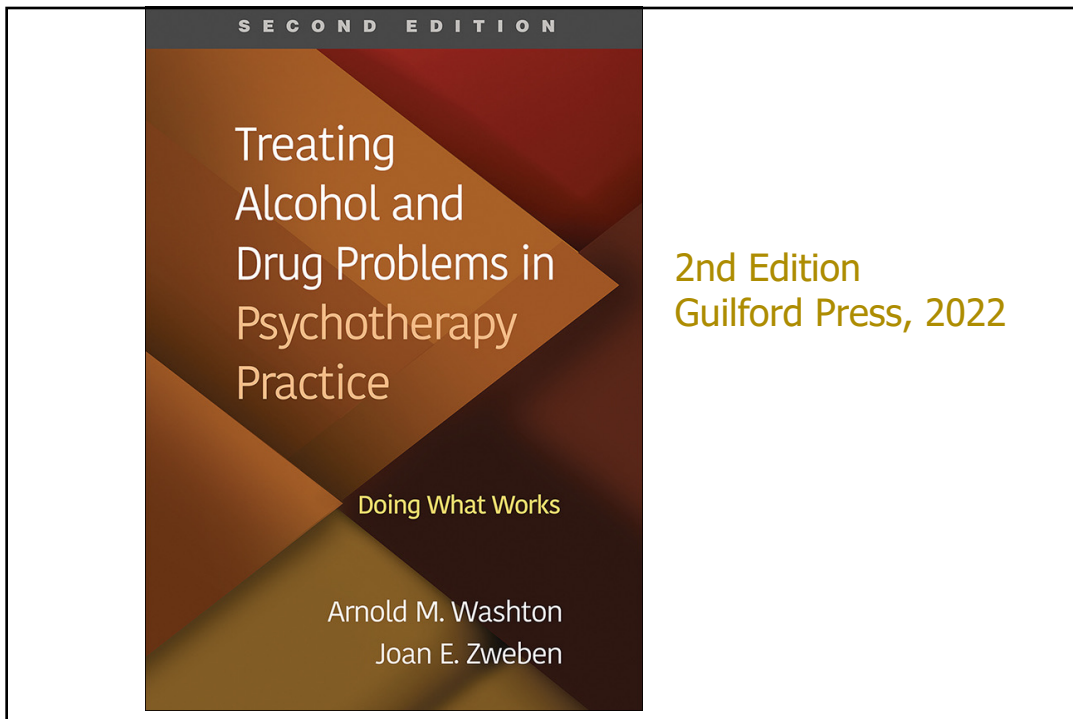
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5



6

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7



Today's Objectives

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

8



Today's Objectives

Especially for those of you who are not addiction specialists:

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

9



Recent Advances

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

10

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Why Psychotherapists are Critical in Addressing Substance Use Disorders

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

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

11

The Therapeutic Relationship **IS** the Primary Vehicle for Change

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



Build Trust First

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



Start Where the Client Is

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



Support Incremental Change

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

12

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Two Major Approaches to Substance Use Disorders

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

Harm Reduction Approach

Philosophical roots: Rogerian client-centered therapy

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

Abstinence-Only Approach

Philosophical roots: AA disease model

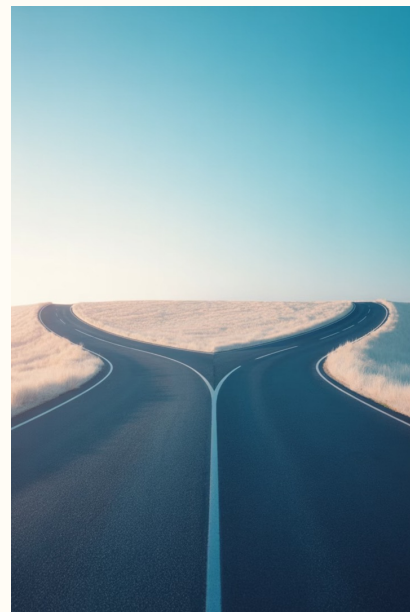
- Requires acceptance of "alcoholic" identity
- Defines success as complete abstinence
- Views controlled use as denial-based illusion
- Emphasizes surrender and powerlessness
- Views setbacks, no matter how limited, as "relapse"
- May encourage strong confrontation ("interventions")

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

13

Two Paradigms of Alcohol Treatment

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



14

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The Disease Model of Addiction

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



Chronic Disease

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



Loss of Control

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



Abstinence Required

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



Mutual Support

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

15



Abstinence-Based Treatment Rationale

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

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

16

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Contemporary Harm Reduction Model

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

Spectrum Disorder

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

Continuum of Severity

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

Individualized Goals

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

Collaborative Approach

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

17



SUD's are SPECTRUM disorders

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

18



SUD's are **SPECTRUM** disorders

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

19

The Moderation Controversy: Examining Both Sides

Disease Model "Abstinence Only" Perspective

Core Belief: Alcoholism is a progressive disease requiring lifelong abstinence

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

Harm Reduction and Moderation Perspective

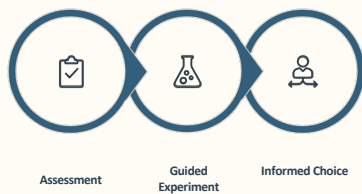
Core Belief: Not everyone with drinking problems has the same needs

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

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

20

Moderation as Strategic Starting Point



Not an Ideology, But a Strategy

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

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

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

21

Harm Reduction

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

22



Basic Harm Reduction Philosophy

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

23



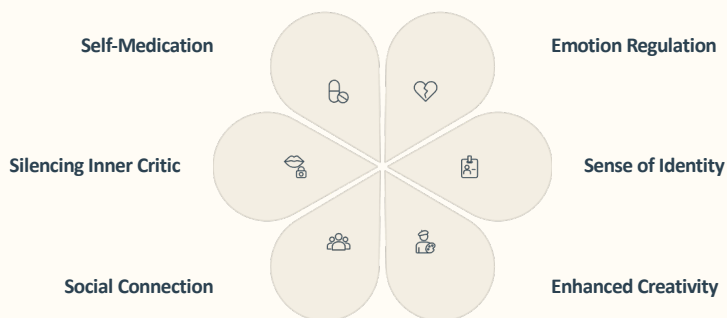
SUDs are “Self- Medication” Disorders

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

24

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Psychodynamic Issues: The Multiple Roles and Meanings of Substance Use



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

25

Rationale for Harm Reduction

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

26



Rationale for Harm Reduction

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

27



Rationale for Harm Reduction

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

28



Rationale for Harm Reduction Approach

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

29



Rationale for Harm Reduction

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

30

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“Moderate Drinking” is only one of many Harm Reduction Goals

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

31

The Stepping-Stone Effect

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

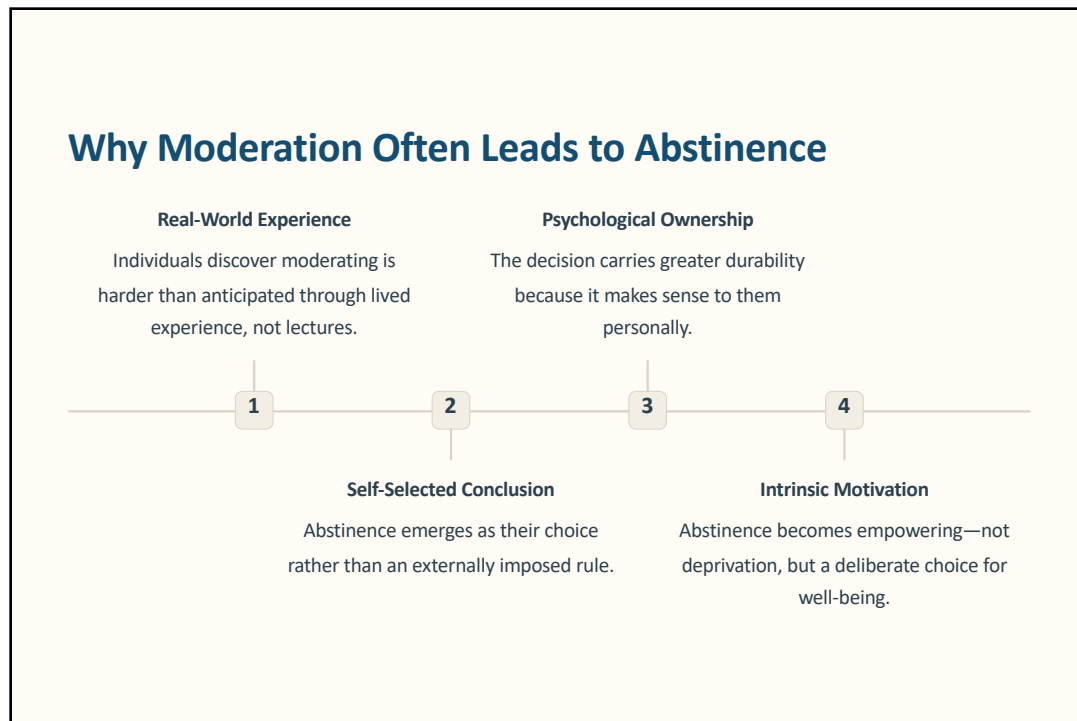
“Many clients with severe AUDs enter treatment only because moderation options were available. Once engaged, some discover abstinence is necessary and transition successfully—a journey they never would have begun if abstinence-only was their only choice.”

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



32

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33



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

Traditional Perspective Abstinence-only views consider offering moderation to heavy drinkers as enabling and potentially harmful, delaying necessary abstinence.	Client-Centered Reality Many clients cannot or will not commit to immediate abstinence. Offering moderation or harm reduction as initial goals can increase engagement, reduce risks, and open doors for future abstinence.
Professional Nuance Responsible practice demands thorough assessment, shared decision-making, and continuous monitoring. Goals remain flexible, adjusting if moderation becomes unsustainable or harmful.	Preserve Relationship and Do No Harm The therapeutic relationship is paramount. Imposing abstinence-only goals prematurely can rupture trust, leading to disengagement. Flexible options foster trust and allow for future progress towards abstinence.

34



Empirical Support

What Does the Research Show?

35

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



36

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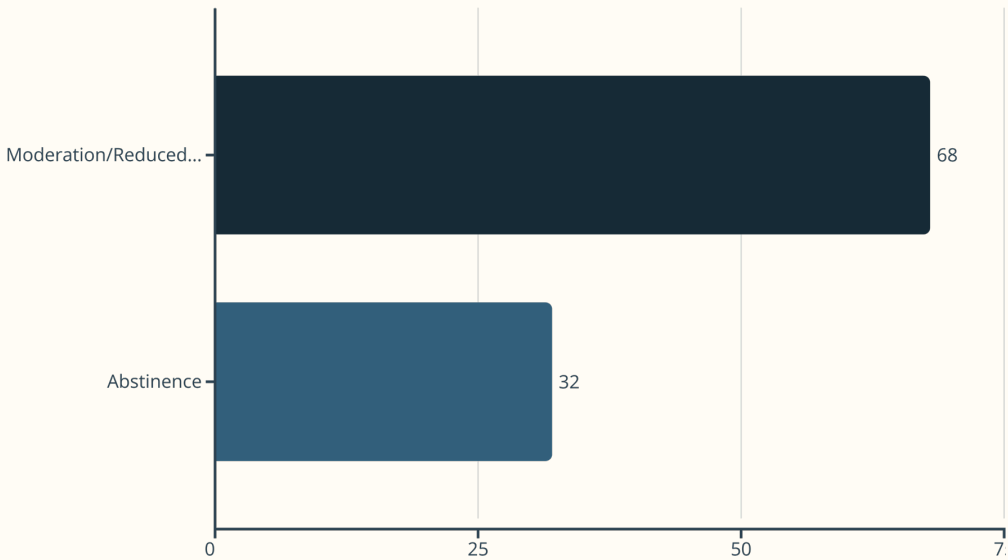
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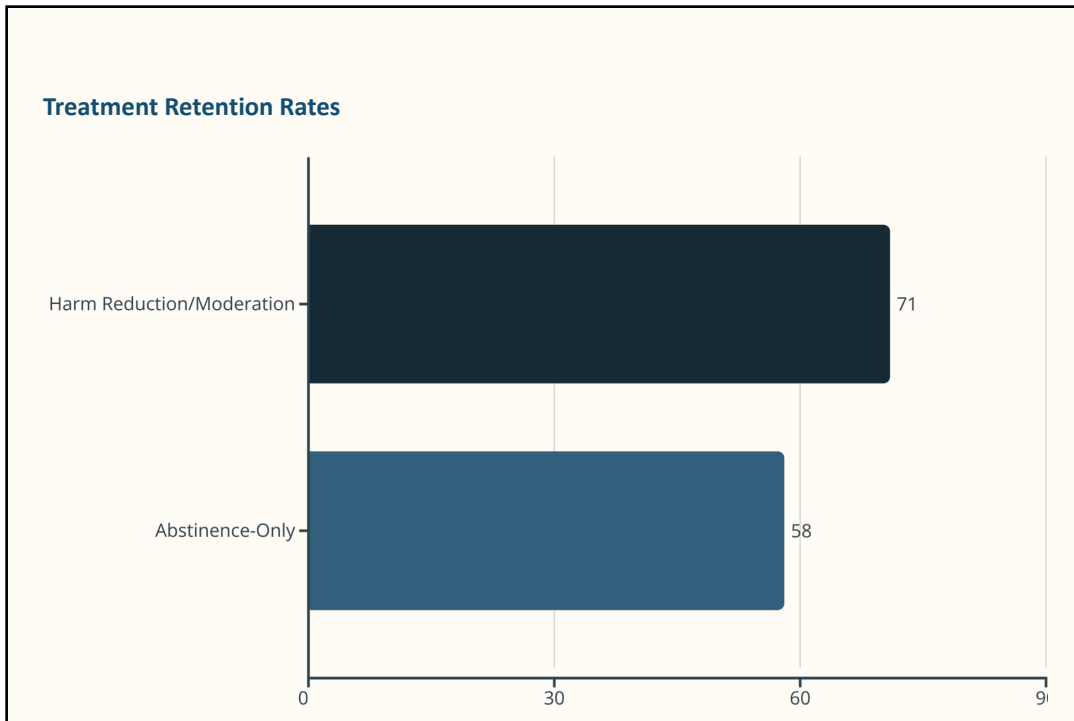
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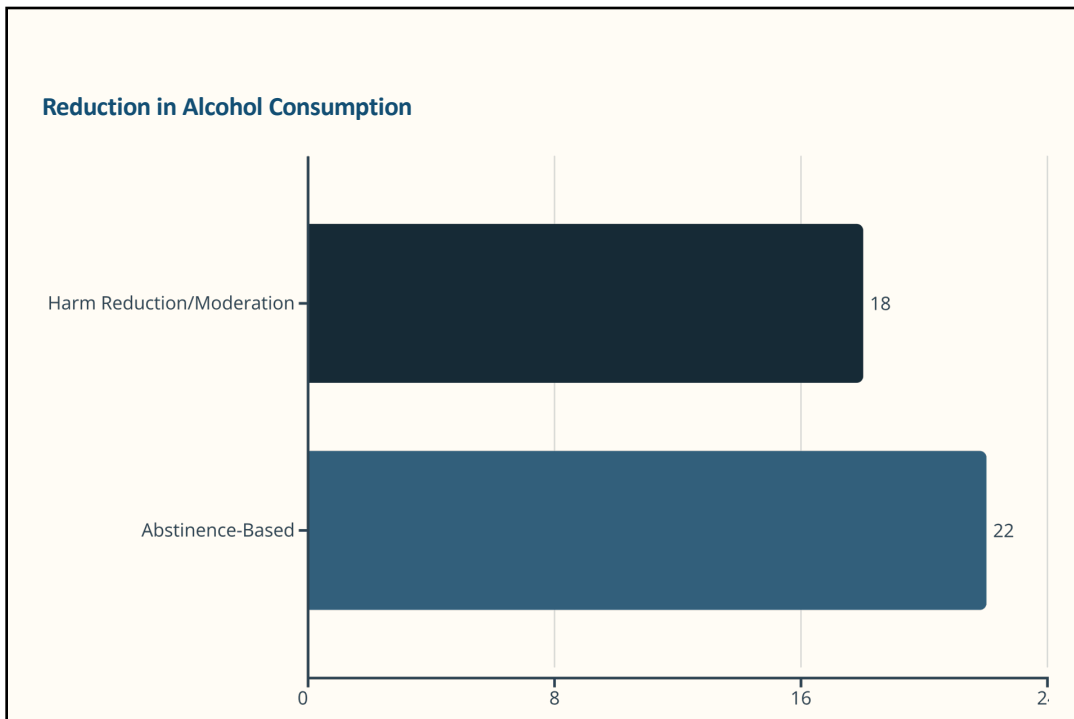
Patient Preference for Treatment Goals



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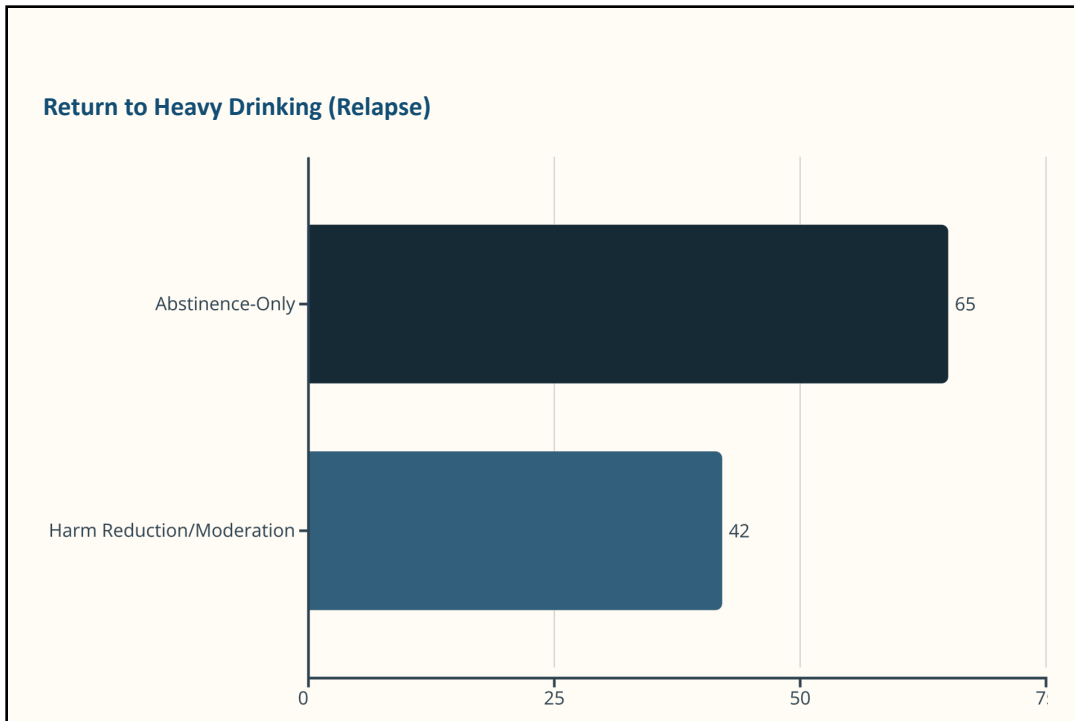


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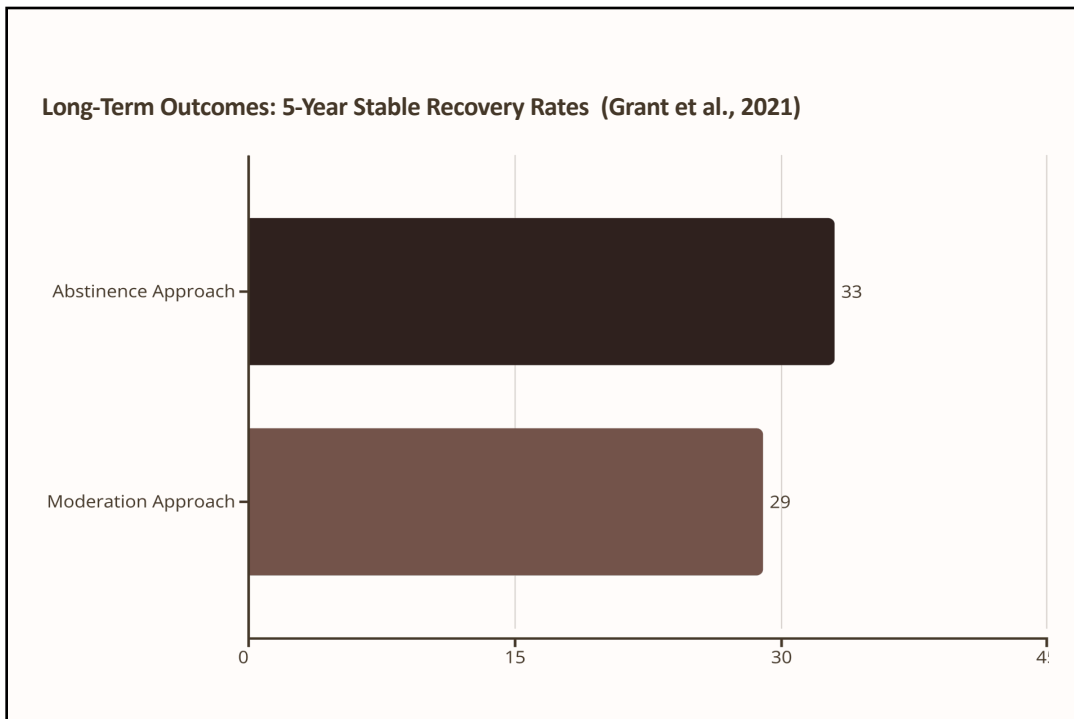


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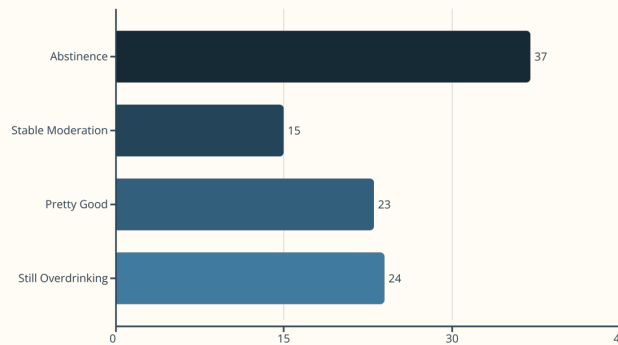


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42

One-Year Statistical Outcomes



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

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

43

LONG-TERM FOLLOW-UP

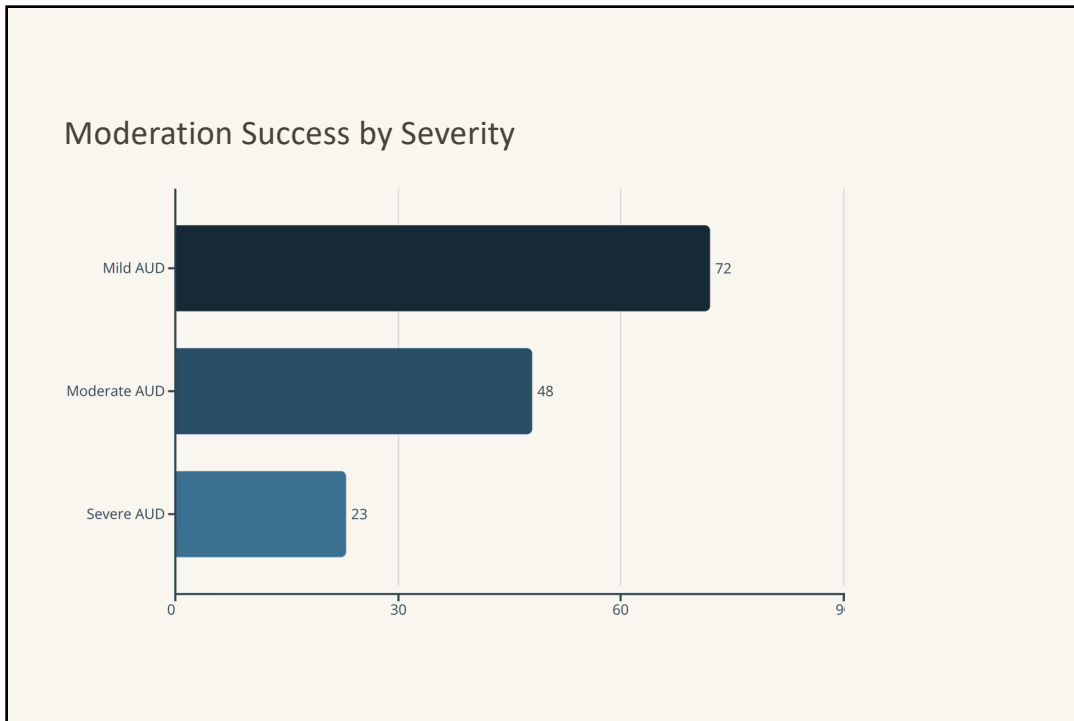
Predictors of Long-Term Success

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

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

44

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45

Who Succeeds with Moderation?

Good Prognosis Indicators	Challenging Prognosis Indicators
• Mild to moderate AUD severity • Shorter duration of problem drinking • Strong social support • Stable employment and housing • No severe medical complications • High self-efficacy and motivation • Good emotional regulation skills	• Severe AUD with physical dependence • Long history of heavy drinking • Multiple failed moderation attempts • Serious medical consequences (liver disease, pancreatitis) • Co-occurring severe mental illness • Legal mandates requiring abstinence • Pregnancy or planning pregnancy

46



ALCOHOL USE ASSESSMENT

47

Assessment: More Than Just Data Gathering

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

Builds Therapeutic Alliance

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

Catalyzes Engagement

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

Fosters Motivation & Hope

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

Empowers Client-Centered Progress

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

48

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Assessment Tools

- **Clinical Interview**
A comprehensive discussion to gather personal history, drinking patterns, consequences, and motivation.
- **The Washton Group New Patient Questionnaire**
A detailed self-report instrument from the Washton Group, available for download at thewashtongroup.com.
- **Alcohol Use Disorders Test (AUDIT)**
A 10-item screening tool developed by the WHO to identify hazardous and harmful alcohol consumption.
- **DSM-5 Criteria**
Utilized to identify the presence and severity of Alcohol Use Disorder based on diagnostic standards.

49

Key Assessment Areas



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



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



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



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



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

50

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Assessing Current Drinking Patterns

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

Daily Drinking (Physically Dependent)

Consistent daily consumption often characterized by physiological withdrawal symptoms upon cessation.

Daily Drinking (Non-Dependent)

Regular daily alcohol intake without developing physical dependence or overt withdrawal symptoms.

Alternating Patterns

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

Weekend Binge Drinking

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

Situational Binge Drinking

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

Emotionally-Triggered

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

Sporadic/Periodic Binge

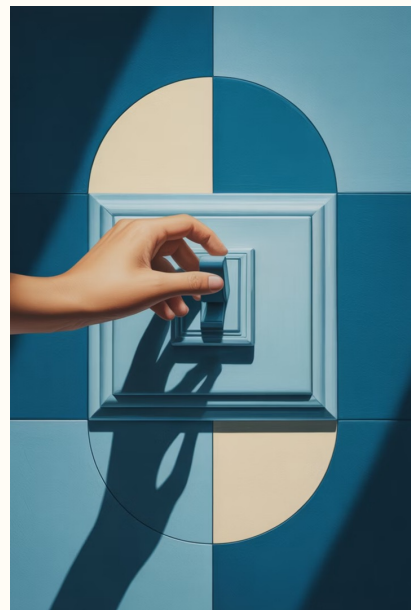
Infrequent, intense drinking episodes followed by extended periods of low or no consumption.

51

How Many Drinks Disable Your "Off Switch"?

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

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



52



Unreliable “Off” Switch

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

53



Binge Drinking

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

54



Binge Drinking

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

55

Why Now?

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Crisis Precipitants

Often, clients seek help following a crisis or negative consequence related to cocaine use. Understanding these precipitating events provides insight into the client's motivation and immediate concerns.

Accumulating Consequences

For many clients, the decision to seek help comes after a gradual accumulation of negative consequences across various life domains, reaching a tipping point where the costs of continued use outweigh the benefits.

External Pressure

Some clients seek treatment due to pressure from employers, partners, or family members. Understanding these external motivators helps gauge intrinsic motivation and identify potential supports or barriers to change.



56



What is your drinking goal?

- ◆ Reduce amount/frequency
- ◆ Reduce risks/consequences
- ◆ Find out if moderate drinking is achievable/sustainable?
- ◆ Eliminate heavy/binge drinking episodes only
- ◆ Avoid serious consequences (legal, physical, marital, etc)
- ◆ Not really sure

57



Clinical Considerations

- ◆ Seeking your help specifically for an alcohol problem or drinking issues were identified in the course of evaluation/treatment for other mental health problems?
- ◆ History of prior specialized treatment for alcohol problems?
- ◆ History of prior attempts to reduce or stop drinking?
- ◆ Current vs. prior motivation and readiness to change
- ◆ Degree of optimism/hope in achieving personal goals
- ◆ What type of help might be best for you?

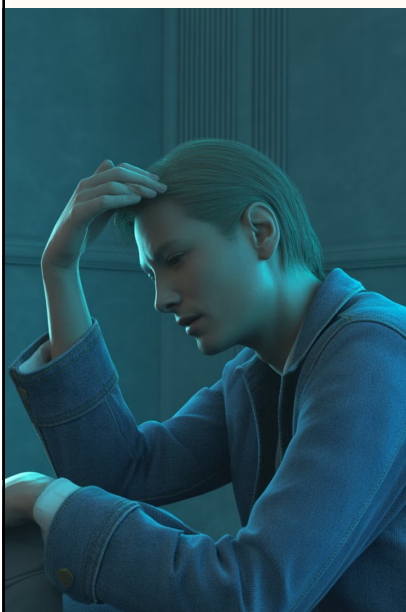
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Key Questions

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

59



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

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

60

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Acknowledging What Drinking Provides



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

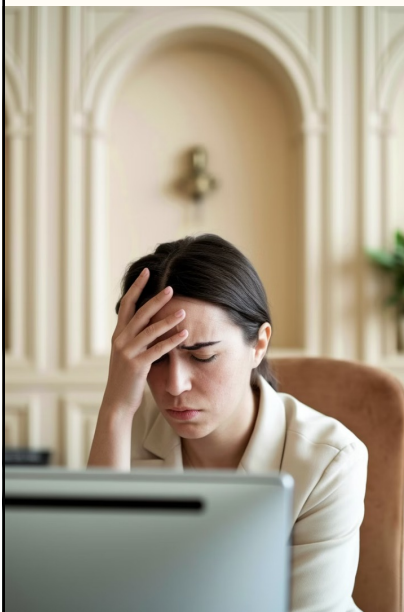
Therapeutic statements that build rapport:

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

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

61

Identifying Your Triggers



Emotional Triggers

Stress, anxiety, loneliness, boredom, celebration, or sadness can trigger drinking.

Social Triggers

Certain friends, family gatherings, work events, or parties may activate drinking.

Environmental Triggers

Specific locations, times of day, or activities might cue your desire to drink.

Internal Triggers

Thoughts, memories, or physical sensations can spark drinking urges.

62

Protective Factors: What Helps You Limit?

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

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

63



Significant Others

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

64

RETHINKING DRINKING

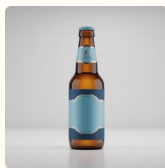
Defining "A Drink"

Standard drink definitions and alcohol "equivalents"



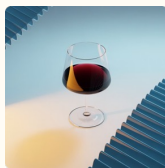
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What Counts as One Standard Drink?



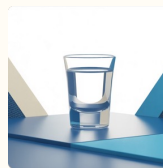
Beer

12 oz at 5% alcohol



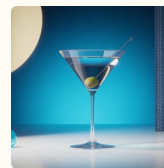
Wine

5 oz at 12% alcohol



Distilled Spirits

1.5 oz at 40% alcohol (80 proof)



Martini

Typically 2-3 standard drinks

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

66

RETHINKING DRINKING



Champagne intoxicates more quickly than wine!

-  **CO2 Bubbles**
Present in champagne and sparkling wines
-  **Accelerated Absorption**
Bubbles speed alcohol into bloodstream
-  **Faster Intoxication**
Alcohol reaches the brain more quickly

67

Common Drinks

-  **Cocktails**
Usually contain 2-3 standard drinks depending on preparation
-  **Bottle of Wine**
A 750 ml bottle holds about 5 standard drinks
-  **"Fifth" of Liquor**
A 750 ml bottle contains 17 standard drinks
-  **Pint of Liquor**
Contains 8.5 standard drinks

Understanding Standard Drinks



68

RETHINKING DRINKING

Pace Matters



Rate of Drinking

Moderate drinking means limiting not only the number of drinks consumed, but also modulating the rate to prevent blood alcohol concentration from rising too quickly.



One Drink Per Hour

For most people, this means drinking no faster than one drink an hour to maintain control and stay within safe limits.

69

How Much Drinking Is Too Much?

The answer depends on who you ask—different organizations use different criteria to define problematic drinking.

70

RETHINKING DRINKING

NIAAA: Drinking Levels Defined

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines drinking levels based on quantity and frequency:

Moderate Drinking

Up to 1 drink per day for women, up to 2 drinks per day for men

Binge Drinking

4+ drinks for women or 5+ drinks for men within about 2 hours

Heavy Drinking

Binge drinking on 5 or more days in the past month

At-Risk Drinking

Exceeding moderate drinking limits, increasing risk of developing alcohol use disorder

☐ NIAAA emphasizes that these are guidelines—individual risk varies based on genetics, health conditions, and other factors.



71

DSM-5 Alcohol Use Disorder Criteria

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

Impaired Control

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

Social Impairment

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

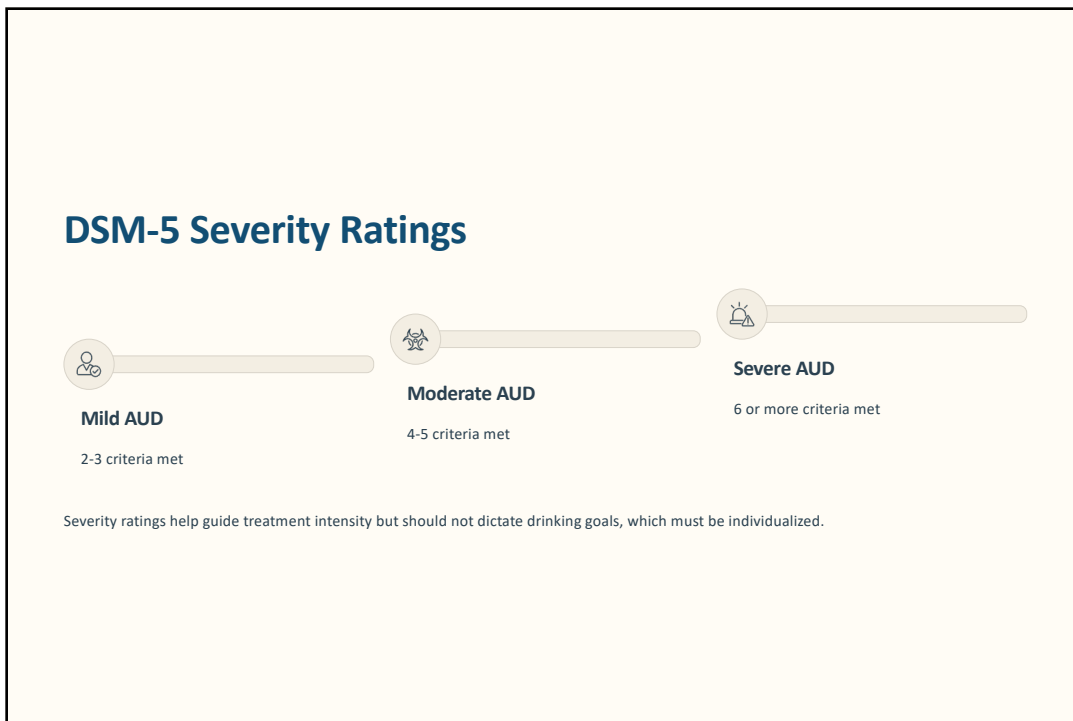
Risky Use

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

Pharmacological

- Tolerance (need more for effect)
- Withdrawal symptoms

72



73

Alcohol Withdrawal

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

74



Assessing Need for Medical Detox

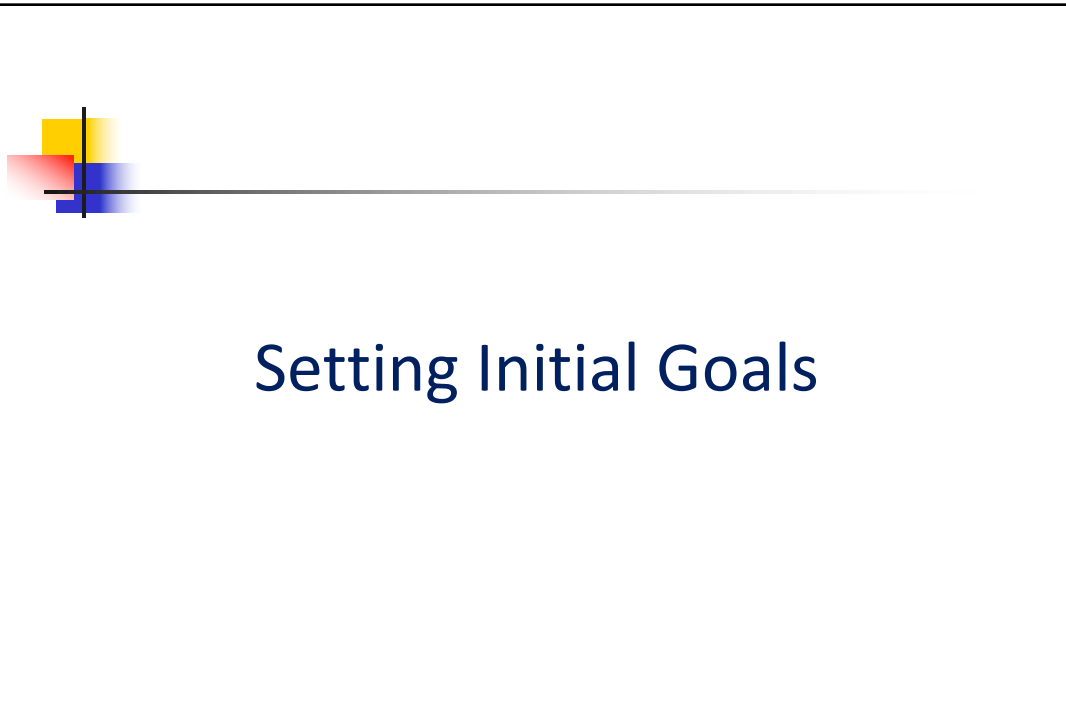
- ◆ When was the last time you stopped drinking for at least 3 or 4 days in a row?
- ◆ How did you feel during those days?
- ◆ Any severe anxiety, agitation, restlessness, insomnia, tremors?
- ◆ Have you ever needed medication in the past to help you stop drinking?
- ◆ Have you ever in an ER or detox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

75

THE DANGERS OF ABUSING Ambien And Alcohol

Alcohol and Ambien both work to slow certain functions, like heartbeat and brain processes. This means that when taken together, these effects are increased and can slow functions to dangerous levels.

76



77

Pros and Cons of Changing

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

A photograph of a woman with dark hair, wearing a light-colored button-down shirt, sitting at a dark wooden desk. She is looking down at a piece of paper on the desk with her hand resting on her chin, appearing thoughtful or stressed. There are some books and a potted plant in the background.

78

RETHINKING DRINKING

Collaborative Goal-Setting

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

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

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



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

79



Abstinence or Moderation?

Start where the patient is

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

Total abstinence is safest

But only the client can choose their path

Consider an "experiment" with Abstinence

Many open to trial period of abstinence

80

RETHINKING DRINKING

Categories of Drinking Goals

Safer Drinking

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

Reduced Drinking

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

Moderate Drinking

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

Tapering ("Warm Turkey")

Stepwise reduction toward eventual abstinence. Allows physiological and psychological adjustment to decreasing amounts.

Abstinence

Complete cessation of alcohol consumption, either temporary or indefinite.

Situational Abstinence

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

81

Some Suggested Starting Points

For patients not requiring medical detox

1

Experiment with abstinence

30-90 days; be willing to compromise

2

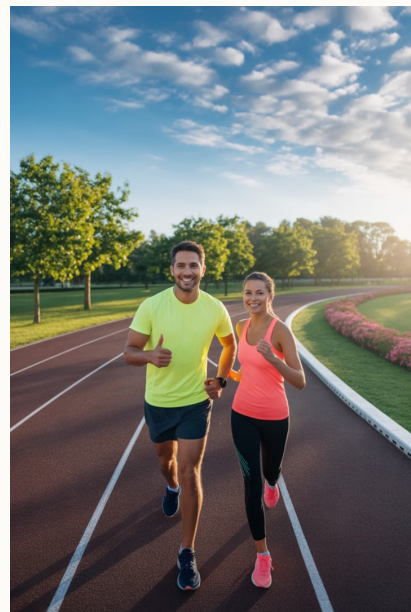
Cut drinking by 50%+

Reduce volume and frequency

3

Follow NIAAA "Low Risk" guidelines

2-3 drinks, 3-4 days/week, not consecutive



82

RETHINKING DRINKING

When Abstinence is Clearly The Best Choice



Pregnancy

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



Medical Conditions

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



Loss of Control

People who become aggressive or violent when they drink.



Drinking & Driving

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



Long-Term Abstinence

People already abstinent for a year or longer due to previous serious problems.

83

The Abstinence "Experiment"

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

Critical Framing

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

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

84

RETHINKING DRINKING



Proposing a temporary break from drinking for 30 days or longer

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

85



Interrupting the Autopilot Drinking Pattern

Many clients drink automatically: the nightly glass of wine when cooking, the drink after putting kids to bed. A brief abstinence period forces the habit loop into conscious awareness and reinforces the practice of **MINDFUL** rather than **MINDLESS** drinking

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

86

RETHINKING DRINKING

Why Do The Abstinence "Experiment?"

1 Reset Baseline & Regain Control A temporary break helps reset physiological and psychological dependence, making future moderation attempts more successful.	2 Gain Clarity & New Perspective Experience life unclouded by alcohol, leading to fresh insights and a renewed understanding of your priorities and capabilities.
3 Rediscover Sobriety's Joys Realize that true contentment and enjoyment don't require alcohol, and often, you function and feel better without it.	4 Practice Refusal Skills Develop confidence in politely declining drinks, navigating social situations without awkwardness or fear of judgment.
5 Observe Drinking Dynamics Gain objective insight into your own and others' behavior during heavy drinking, and evaluate the true nature of certain social connections.	6 Reduce Alcohol Tolerance Lower your tolerance, allowing you to experience desired effects at much smaller doses if you choose to reintroduce alcohol in moderation.

87

Benefits of an Abstinence Experiment



Breaks Automatic Patterns

Disrupts habitual drinking on "autopilot" and creates space for conscious choice-making about drinking behavior.



Eliminates All Risk

Provides complete protection from alcohol-related consequences during the abstinence period—clearly the safest choice.



Reveals Role of Alcohol

Shows thinking, feeling, and behaving patterns without alcohol—information simply not available while continuing to drink.



Exposes Emotional Patterns

Reveals extent of reliance on alcohol for mood regulation, stress management, and emotional coping.

88

RETHINKING DRINKING

Benefits of an Abstinence Experiment



Enhanced Clarity

Notice clearer thinking, improved focus, and better memory, allowing for more effective problem-solving and decision-making without alcohol's influence.



Discover New Enjoyments

Open up to new hobbies, social activities, and ways to relax that don't involve alcohol, broadening your sources of pleasure and satisfaction.



Boosted Self-Efficacy

Successfully completing a period of abstinence builds significant confidence and a sense of mastery, empowering future moderation efforts.



Improved Physical Well-Being

Notice increased energy levels, alertness, stamina, and potential weight loss.

89

Benefits of an Abstinence Experiment



Improved Sleep Quality

Enjoy more restorative sleep, free from alcohol's disruptive effects. Wake up feeling refreshed and energized, a stark contrast to restless, alcohol-induced nights.



Increased Financial Savings

Witness direct financial benefits as you eliminate alcohol purchases. This saved money can be redirected towards other meaningful goals or experiences.



Practice New Coping Skills

Actively engage in developing healthier ways to manage stress, boredom, and emotions, rather than relying on alcohol. Build a robust repertoire of alternative coping mechanisms.



Reduced Anxiety & Depression

Experience a potential reduction in alcohol-related anxiety and depressive symptoms, leading to improved overall mood stability and emotional well-being.

90

RETHINKING DRINKING

Benefits of an Abstinence Experiment



Reduced Tolerance & Cravings

A temporary break can reset your body's tolerance to alcohol, making it easier to adhere to moderate limits later and potentially diminishing the intensity of cravings.



Increased Awareness of Triggers

Without the immediate influence of alcohol, you can more clearly identify the specific situations, emotions, or social cues that typically prompt you to drink.



Enhanced Self-Control

Successfully completing a period of abstinence strengthens your mental fortitude and practices vital self-regulation skills, essential for achieving sustained moderation.



Reconnection with Values

This period allows you to reconnect with your core values, passions, and long-term goals, ensuring your actions align more effectively with what truly matters to you.

91

Benefits of an Abstinence Experiment



Provides Rapid Wins

Abstinence creates immediate visible change, building confidence and self-efficacy quickly



Identifies Triggers

Clarifies internal and external activators of drinking urges without the confounding effects of intoxication



Reduces Family Conflict

Begins rebuilding trust with concerned family members and significant others



Tests Difficulty Level

Reveals how easy or difficult stopping actually is—valuable prognostic information

92

Benefits of an Abstinence Experiment



Exposes Unmet Needs

Reveals voids in life being masked or medicated by drinking



Enhances Medication Effectiveness

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



Creates Emotional Access

Provides opportunity to experience and learn healthier ways of managing emotions



Gives Your Brain A Chance to "Reset"

Allows time for some of the biochemical impact of alcohol on your brain to dissipate

93



Surprisingly Good Acceptance of a Proposed "Experiment" with Abstinence

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

94



Initiating Abstinence: Quitting Strategies

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

95



Craving Management Techniques

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

96

RETHINKING DRINKING



How Urge Surfing Works

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

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

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

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



97

Drink Refusal Skills

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

"I decided to stop drinking for a while."

"I'm not interested in drinking tonight."

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

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

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

98

RETHINKING DRINKING



Abstinence-Supportive Strategies

01

Remove Alcohol from Home

Eliminate temptation by clearing out all alcoholic beverages.

02

Develop New Routines

Replace drinking rituals with healthy alternatives and new habits.

03

Build Sober Support Network

Connect with others in recovery through AA, SMART Recovery, or therapy groups.

04

Practice Refusal Skills

Rehearse how to decline drinks confidently in social situations.

99



Maintaining Your Social Life Without Drinking

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

100

Navigating Early Slips: Therapeutic Approaches

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



101

Learning from Slips

Definition

Brief episode falling short of full return to former drinking pattern

Therapeutic Approach

Address non-judgmentally, reframe as avoidable but informative

Analysis

Review scenario and circumstances to prevent recurrence.

Common Trigger

Often preceded by boredom, stress, desire to “test control”.



102



Results of the Abstinence "Experiment"

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

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

103



Results of the Abstinence "Experiment"

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

104



Results of the Abstinence “Experiment”

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

105



Not Ready or Willing to Take a Break from Drinking?

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

106



Non-Abstinence Goals

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

107



Moderation Strategies

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

108



“IDEAL” Drinking Plan

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

109



Self-Control Strategies

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

110

RETHINKING DRINKING

Behavioral Self-Control "Toolkit"

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

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

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



111

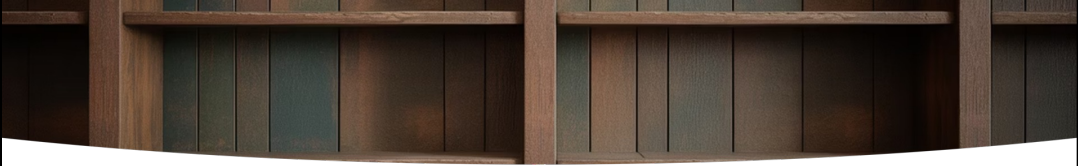


HANDOUT: 10 Drinking Control Strategies

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

112

RETHINKING DRINKING



Self-Control Techniques: Beverage Choices

Don't Drink for the Buzz

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

Switch to Lower Proof

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

Don't Keep Alcohol at Home

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

113

Self-Control Techniques: Social Strategies

Avoid Drinking Alone

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

Careful with Heavy Drinkers

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

Prepare Refusal Skills

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

114

Mutual-Help Groups and Other Resources Supporting Moderation

www.moderation.org

When Moderation Doesn't Work: Making the Shift

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

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

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

A wooden signpost stands in a grassy field with trees in the background. The signpost has several directional signs attached to it, each pointing in a different direction. The signs are weathered and have some text on them, though it's difficult to read. The scene is lit with soft, natural light, suggesting a forest or park setting.

www.thewashtongroup.com pg 58

Therapeutic Responses to Moderation Struggles

01

Acknowledge the Effort

"You've given moderation a genuine try. That took courage and commitment."

02

Normalize the Experience

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

03

Highlight Learning

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

04

Introduce Abstinence Gently

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

05

Support the Transition

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

117

Non-Alcoholic Drinks in Recovery: Help or Hindrance?



118

RETHINKING DRINKING

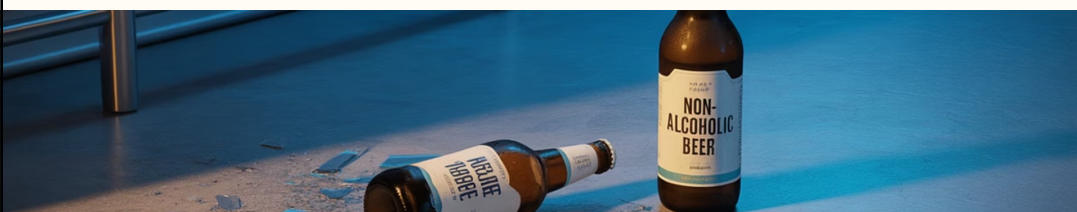
Potential Benefits

**Social Inclusion**
Helps maintain social engagement without isolation

**Mindful Drinking**
Promotes awareness and control of consumption habits

**Psychological Relief**
May reduce cravings by mimicking ritual without alcohol

119



Potential Risks

1

Psychological Triggers
Taste and smell can evoke cravings

2

Reinforced Habits
May maintain attachment to drinking rituals

3

Slippery Slope
Could rationalize "just one real drink"

120



Cannabis and Alcohol Moderation: Help or Hindrance?

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

121



Cannabis as a Substitute for Alcohol: Promising Evidence

Clinical Research Study of 96 heavy drinkers in treatment showed 29% fewer drinks and 2× less binge drinking on cannabis-use days (Karoly et al., 2021)	Population Trends Medical cannabis users report using cannabis specifically to reduce alcohol intake; states with lenient cannabis laws see measurable decreases in overall alcohol consumption
Strain Differences CBD-dominant cannabis linked to fewer drinking days and less co-use compared to THC-heavy strains (University of Colorado study)	

122

RETHINKING DRINKING

Risks and Challenges of Cannabis Use in Alcohol Moderation



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

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

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

123

Medications That May Help with Moderation or Abstinence



124

RETHINKING DRINKING

Role of Medications

Reduce Craving

Make it easier to cut down or stop by decreasing urges and reward

Support Abstinence

Reinforce time-limited abstinence by decreasing urges and building self-efficacy

Prevent Relapse

Blunt reinforcing effects after a slip to prevent full relapse

125

Adjunctive Medications

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



Naltrexone

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



Disulfiram (Antabuse)

Creates unpleasant reaction if alcohol is consumed, serving as a deterrent to drinking.



GLP-1 Agonists

Emerging evidence suggests medications like semaglutide may reduce alcohol consumption and cravings.



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

126

Psychologist's Role in Pharmacotherapy

What Psychologists Can Do:

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

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

127



Naltrexone (ReVia, Vivitrol)

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

128



Antabuse (disulfiram) can be extremely helpful!

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

129



Antabuse (Disulfiram) can be extremely helpful!

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

130

Antabuse (Disulfiram) can be extremely helpful!

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

131

GLP-1 Agonists: Emerging Evidence

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

Preliminary Findings

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

Current Status

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



132



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

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

133



Oral Semaglutide for Alcohol Use Disorder

Schacht, J. P., Sakai, J. T., Raymond, K., & Shelton, R. (2026). Oral semaglutide for alcohol use disorder: A randomized clinical trial. *American Journal of Psychiatry*, 183(9), 636–645.

- ◆ 50 patients with moderate to severe AUD
- ◆ Oral semaglutide (*Wegovy*) 3 mg/day for 4 weeks, then 7 mg/day or placebo for 7 weeks (typical weight loss dose is often 7-15 mg/day)
- ◆ Outcome measures:
 - ◆ Cue-elicited and “naturalistic” alcohol craving scores
 - ◆ “Heavy” drinking days during last 4 weeks
 - ◆ Drinks per day during last 4 weeks
 - ◆ Alcohol-related negative consequences (PROMIS)

134

Key Findings

- ◆ Active medication vs. placebo group
- ◆ Significant reduction in “heavy” drinking days and average number of drinks per drinking day
- ◆ No significant reduction in weekly frequency of drinking; i.e., average number of drinking days per week
- ◆ Significant reduction in negative consequences (PROMIS)
- ◆ Significant reduction in “naturalistic” cravings, but not in cue-elicited cravings in laboratory environment
- ◆ Questions: higher dosages, longer treatment and follow-up??

135



Case Vignettes: Multiple Pathways to Incremental Change

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

136



Structure & Format of My Clinical Practice

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

137



Structure & Format of My Clinical Practice

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

138

RETHINKING DRINKING



Structure & Format of My Clinical Practice

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

139

Five Unique Journeys

Nilia

Brief abstinence → stable moderation

Doreen

Abstinence → moderation transition

Paul

Multiple moderation attempts → stable abstinence

Cedrick

One year abstinence → 3+ years stable moderation

Victor

Requested moderation but eventually opted for abstinence



140

RETHINKING DRINKING

Meet "Nila"

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

The Struggle

Five years of alcohol blackouts

The Trigger

Relationship end + father's health decline



141

Nila's Journey to Treatment

Treatment History

Two years of psychotherapy with limited progress

The Escalating Pattern

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

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

142

Nilā's Initial Presentation

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

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

143

Initial Treatment Planning

1

Explore Options

Compare moderation and abstinence approaches.

2

Try an Experiment

Frame abstinence as a time-limited trial.

3

Reduce Resistance

Address ambivalence and practical barriers.

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

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

144

Establishing the Treatment Framework

Treatment Structure

Weekly individual sessions for 12 weeks

Group Participation

Nila declined weekly support group; option kept open

Initial Focus

Identified high-risk situations and drinking triggers



145

Understanding Nila's Drinking Patterns



Social Drinking

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



Isolation Pattern

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



Early Setbacks

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

146

Developing Self-Control Strategies

Practical Strategies

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

Uncovering Emotional Drivers

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

Profound Revelation

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

147

Building Support and Refining Goals

1

Enlisting Social Support

Nila enlisted friends' support, asking them not to encourage overdrinking

2

Collaborative Care

Regular contact with therapist ensured coordinated care. Two paths: reduce drinking to monthly or complete 30-day break

3

Progress and Challenges

Reduced drinking amount and frequency. Still, two severe intoxication incidents occurred, triggered by relationship issues

148

RETHINKING DRINKING

Nila's Path to Recovery

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

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

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



149

Meet "Peter"



Personal Background

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



Drinking History

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



Growing Concerns

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



150

Peter's Initial Presentation

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

Previous Treatment Failures

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

The Critical Factor

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

151

Peter's Relationship with Alcohol

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

The Turning Point

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

His Request

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

152

Peter's Treatment Journey

1

Two-Week Abstinence "Experiment"

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

2

Extended Experiment for Two More Weeks

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

3

Joined Weekly Support Group

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

Peter's Path to Sustained Recovery

01

Months 1-4: The Exploration Phase

Peter alternated 4-5 cycles of moderation and abstinence. Chronic anxiety subsided with reduced alcohol. Psychiatrist prescribed lorazepam for breakthrough anxiety.

02

Month 4: The Turning Point

After four months in the group, Peter chose complete abstinence. This decision stemmed from growing awareness, not external pressure.

03

Years 1-4: Sustained Sobriety

Peter maintained continuous sobriety for four years, continuing weekly individual and group therapy.

04

Ongoing Work: Deeper Issues Emerge

Addressed chronic anger towards wife, emotional dependence on parents, lifelong self-esteem deficits, and parenting challenges.



Meet "Dayna"

55-year-old businesswoman referred by couples therapist.

1

Nightly Glasses: 2-3
Consistent weeknight pattern

2

Weekend Glasses: 5-8
Escalating weekend consumption

3

Days in Rehab: 28
Two years earlier, under family pressure

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

155

Dayna's Initial Presentation

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

 **The Catalyst**

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

156

Establishing a Treatment Alliance

Balancing Honesty and Hope

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

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

The Abstinence Experiment

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

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

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

157

Building the Foundation for Change

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



Trigger Identification

Mapped drinking triggers and developed management strategies



Time Planning

Structured evenings and weekends with alternative activities



Support System

Identified support and accountability sources beyond family

158

Navigating Family Dynamics



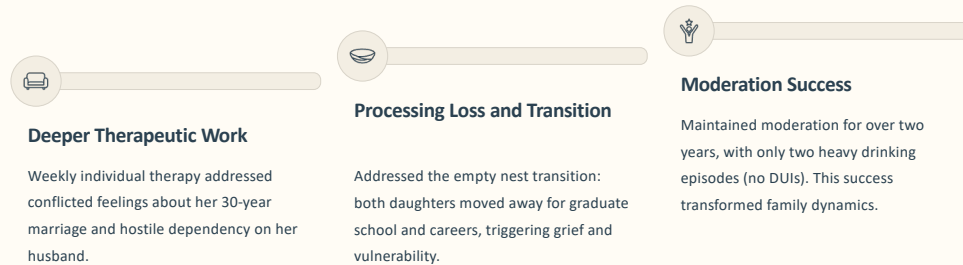
At our next meeting, Dayna's husband expressed strong disagreement with my moderate drinking philosophy. His concerns were understandable: all previous moderation attempts had failed.

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

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

159

Dayna's Ongoing Recovery



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

160

RETHINKING DRINKING



Meet "Cedrick"

Demographics 34-year-old real estate broker, married with no children	Drinking History College binge drinking and marijuana use, recent return to binge drinking with partial blackouts	Crisis Point Sexual encounter with former girlfriend during college reunion drinking binge, confessed to wife one week before seeking treatment
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161

Cedrick's Initial Presentation

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

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

162

Beginning Cedrick's Recovery Journey

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

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

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

163



Navigating Early Sobriety Challenges

- 1 Social Adjustments**

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

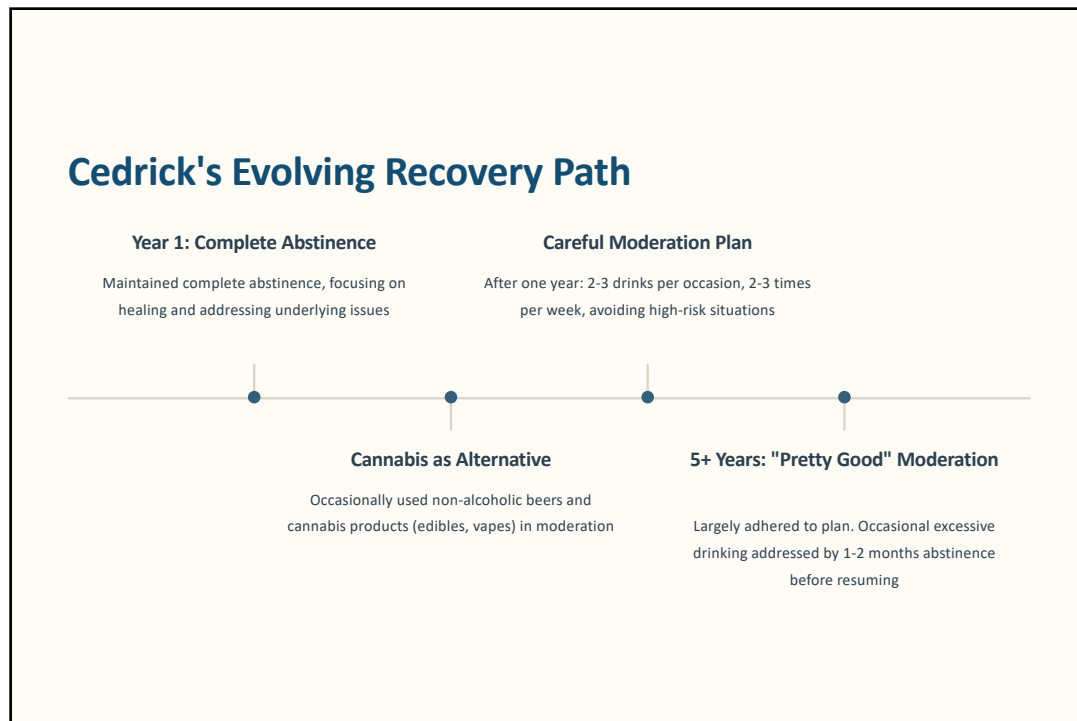
This common early recovery challenge involves recognizing that some relationships and activities are temporarily incompatible with sobriety.
- 2 Uncovering Marital Dissatisfaction**

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

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

164

RETHINKING DRINKING



165

Meet "Victor"

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

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

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

166

RETHINKING DRINKING

Victor's Pattern: Relapse After Monitoring

1

10 Years Ago: Initial Intervention

Victor was reported to a physician monitoring program after an OR nurse smelled alcohol on his breath. He was sent to inpatient rehabilitation.

2

5 Years of Monitored Sobriety

He remained sober for 5 years in the monitoring program, which included regular urine testing and mandatory AA meetings.

3

Additional Year of Independent Sobriety

After the monitoring program, Victor remained sober for an additional year independently, without treatment or AA.

4

Relapse Triggered by Life Changes

Last year, Victor relapsed. This coincided with his youngest daughter leaving for college (empty nest) and his anesthesia group losing their hospital contract.

Victor sought treatment due to his wife's ultimatum: get help or she would end the marriage.

167

Victor's Current Drinking Pattern and Treatment Entry

The Pattern

Victor described secretly drinking late at night, but only on his days off. While this showed some internal control, the secretive nature was troubling.

He and his wife confirmed he never went to work intoxicated or hungover, indicating some retained professional boundaries.

Treatment Agreement

Victor did not want to stop drinking completely, stating that he enjoyed drinking a great deal and wanted to find a way to manage and control it.

Recognizing his wife's ultimatum, Victor agreed to a 90-day break from drinking. Doubting his ability to control cravings, he was receptive to taking Antabuse (disulfiram).

168

Uncovering the Role of Work Anxiety

1

Two Months Abstinence

Completed Antabuse-supported sobriety

2

Recognition of Anxiety

Alcohol had masked work-related anxiety

3

Psychiatric Evaluation

Assessment led to gabapentin prescription

After two months of abstinence on Antabuse, Victor realized alcohol had masked significant work-related anxiety—both acute stress during procedures and chronic tension regarding performance, outcomes, and responsibilities.

This reframed his drinking: it wasn't enjoyment but self-medication for long-unrecognized anxiety. The high-stakes nature of anesthesiology, where errors are catastrophic, created constant, accumulating stress.

Victor was referred for psychiatric evaluation. He received gabapentin (Neurontin), an anti-anxiety medication without addiction risks, which proved highly effective.

169

Victor's Sustained Recovery and Future Considerations



Group Participation

Despite initial reluctance, Victor joined the weekly Healthcare Professionals Group



Two Years of Sobriety

Victor has maintained sobriety for two years, with one disclosed lapse during a social gathering



Retirement and Reflection

Victor retired from anesthesia last year. The idea of moderate drinking still tempts him occasionally



Deeper Awareness

Through group and individual sessions, he dismisses moderation as "wishful thinking"—genuine insight and wisdom

Victor's case highlights: the value of harm reduction, addressing co-occurring anxiety, the benefits of profession-specific support groups, and how recovery preferences evolve. His journey from relapse to sustained recovery shows change is possible, often by addressing underlying issues masked by alcohol.

170



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171