A Closer Look at Problem Drinkers

Mark B Sobell
Linda C Sobell

A Closer Look at Problem Drinkers

MARK B. SOBELL
LINDA C. SOBELL

Table of Contents

A Closer Look at Problem Drinkers

Studies of Problem Drinkers

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

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

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

While the three domains of problems will often overlap (i.e., evidence of all three types of consequences may be apparent), problem drinkers suffer largely from problems related to intoxication. Their drinking is typically not characterized by features such as compulsive alcohol seeking, daily drinking, or by high blood alcohol levels sustained over lengthy periods of time. Yet, it is these features of severe dependence that many existing treatment programs are designed to address. The problem drinker's troubles are more related to drinking episodes that get out of hand, to consequences of

drunkenness, and to recognizing that they sometimes consume more alcohol than they planned.

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

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

Problem Drinkers in the Research Literature

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

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

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

An appreciation of the differences between problem drinkers and more severely dependent individuals can be achieved by comparing pretreatment characteristics of both populations as reported in the literature. Table 3.1 presents such a comparison displaying variables from eight studies involving

severely dependent persons and six studies involving problem drinkers, including a study of guided self-management treatment. The severely dependent alcohol abusers were all recruited from inpatient treatment programs except for one study (Kuchipudi, Hobein, Flickinger, & Iber, 1990), which involved persons hospitalized for recurrent alcohol-related pancreatitis, ulcers, or liver disease (62% had diagnosed cirrhosis). All of the problem drinkers received brief outpatient treatment, and in all of the problem drinker studies except the one involving guided self-management, the subjects were solicited by newspaper advertisements.

TABLE 3.1.

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

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

Sanchez-Craig et al. (1984)	70	26	47	–	19	14	14	35	5
Sanchez-Craig et al. (1991)	96	36	56	75	–	12	15	40	5
Skutle & Berg (1987)	43	21	63	98	–	–	13	43	–
Guided self-management study	100	36	49	88	–	13	15	37	6

[a]Michigan Alcoholism Screening Test (possible scores 0-53).

[b]Alcohol Dependence Scale (possible scores 0-47).

[c]Veterans Administration Program.

[d]Short Version.

[e]87% had a drinking problem for more than 10 years.

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

Motivationally, two factors are important clinical considerations when working with problem drinkers. First, while problem drinkers typically have not suffered multiple serious consequences from their drinking, they usually are aware that they could suffer serious consequences if their drinking problem continues. This can provide an incentive for change. However, if treatment demands are too great, then noncompliance can be expected (Miller, 1986/ 1987; Pomerleau, Pertschuk, Adkins, &

Brady, 1978). This occurs because problem drinkers' lives usually have not been so damaged by their drinking problems that they are ready to make large sacrifices to comply with treatment. The demands of treatment compete with their work, family, and personal needs. Since traditional treatments, and especially Minnesota Model treatments, are very demanding, this is another reason why alternative treatments are needed for problem drinkers.

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

1. Problem drinkers do not have a history of severe alcohol withdrawal symptoms.
2. Problem drinkers tend to have a shorter problem drinking history, typically around 5 years, and seldom over 10 years.
3. Problem drinkers tend to have greater social and economic stability.
4. Problem drinkers tend to have greater personal, social, and economic resources to call upon in treatment (i.e., they have more opportunity to help themselves).
5. Problem drinkers are not likely to view themselves as different from persons who do not have drinking problems (i.e., they do not self identify as alcoholic, and their self-esteem is usually higher than persons with more severe histories).
6. Problem drinkers can become caught in a motivational dilemma, knowing that they still have a great deal to lose but also feeling that conditions in their life are not so bad as to justify extensive life changes or sacrifices to deal with their drinking.

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

A Close Look at a Group of Problem Drinkers

A brief look at some of the problem drinkers we recently treated in a study at the Addiction Research Foundation will support many of the features discussed above. These individuals were voluntary admissions to a treatment agency. They did not respond to advertisements as has been

common in research studies of treatments for problem drinkers (e.g., Miller, Taylor, & West, 1980; Sanchez-Craig, Annis, Bornet, & MacDonald, 1984; Sanchez-Craig, Leigh, Spivak, & Lei, 1989). That these clients presented themselves for treatment is important because another study conducted at the same agency that used walk-in and solicited clients found that the two groups differed in an interesting way (Zweben, Pearlman, & Li, 1988). Clients solicited by advertisement described themselves as heavier drinkers and perceived themselves as more dependent than those who had sought out treatment. Ad respondents also reported having suffered fewer consequences from their drinking. Two other studies of problem drinkers have reported similar results (Sobell, 1993; L. C. Sobell & M. B. Sobell, 1992a; Hingson, Mangione, Meyers, & Scotch, 1982). These results suggest that it might be the impact of drinking-related consequences rather than the excessiveness of the drinking that motivates problem drinkers to seek treatment.

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

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

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

This group of problem drinkers also showed good evidence of social stability: 88% were employed, and 49% were married. The average education level was nearly 15 years, and 87% had at least a high school education. In another study at the same agency with a different group of outpatients (Sobell,

Sobell, Bogardis, Leo, & Skinner, 1992), it was found that those who had at least some university education were significantly more likely to prefer to select their own treatment goal than were those with less education. It may be that education level is a characteristic of the problem drinker population that is attracted to self-management treatments. In areas other than alcohol problems, it has been found that better educated, older adults were most likely to complete self-administered treatment programs (Scogin, Bynum, Stephens, & Calhoon, 1990).

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

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

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

In a study of medical-ward patients with and without alcohol problems, Lloyd, Chick, Crombie, and

Anderson (1986) found that a criterion equal to approximately 26 drinks per week was the best cutting point for separating problem and nonproblem drinkers. Sanchez-Craig (1986) found that 12 standard drinks per week (no more than 4 drinks per day on no more than 3 days per week) best distinguished problem-free from problem drinkers. Finally, Hester and Miller (1990) and Harris and Miller (1990) have recommended a weekly limit of 17.5 standard drinks as a success criterion for reduced drinking. While the cohort reported here may have been relatively light drinkers among persons with alcohol problems, prior to treatment they were drinking at or above hazardous levels.

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

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

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

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

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

TABLE 3.2.

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

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