The World Health Organization identifies "The harmful use of alcohol [as] a global problem which compromises both individual and social development. It results in 2.5 million deaths each year. Alcohol is the world's third largest r isk factor for premature mortality, disability, and loss of health." (WHO) Yet, perhaps because of our collective affection for beverage alcohol, we don't get alarmed. As Frank Bruni points out in his commentary on the death of Whitney Houston, it's other drugs that make the headlines. (New York Times)

But some of us are too close to the dangers of alcohol to be complacent—perhaps because we witness alcohol problems as a family member or treat addiction as a clinician. Fortunately, our roles give us opportunities to help people at risk to better see the dangers for themselves and, therefore, become more likely to change. When we offer help, however, some styles work better than others. For example, if we try to control a person with an alcohol problem, he or she will probably drink anyway.

People with alcohol problems have their own denial, so it can be difficult if not impossible to make a lasting impression. A man in his forties was hospitalized with a painful episode of pancreatitis and his doctor told him to stop drinking alcohol. He did. But right after the follow-up visit during which the doctor declared his enzyme levels were back to normal, the man resumed drinking. When hospitalized next, he had alcoholic liver disease as well as recurrent pancreatitis. We don't know about the style of the doctor when he instructed the patient the first time, but research shows that doctors advising patients with alcohol problems get far better results if their tone of voice reflects concern rather than anger.

Guides to effective style are available and can help us help people at risk. Maintaining unconditional positive regard (per psychologist Carl Rogers simply psychology) is still clinically appropriate—especially because the latest neuroscience adds support for that and other humanistic elements such as respect, empathy, and caring. Now therapists such as Daniel Siegel, Allan Schore, and Louis Cozolino reference the findings of interpersonal neurobiology (interpersonal neurobiology) when they encourage us to create positive connections with those we wish to help.

But warmth all by itself can be counterproductive. We need a positive interpersonal relationship with whomever we want to help, but we also need to highlight the harmful consequences of the person's alcohol consumption. Balance acceptance of the person with realities such as hurtful behavior at home, worrisome lab values, or substandard job performance. Balance hope and affirmations with realities such as what nature will do (damage organs) or what you will do (suspend or terminate the relationship) if nothing changes. Motivational Interviewing actually teaches a style that is empathic, affirming, and avoids argument while reminding people that they are responsible for the path they follow and the consequences that lie ahead. (motivational interviewing) These techniques help people commit themselves to healthier choices that they were too ambivalent to follow before.

Family members and clinicians can learn to get the balance right. A woman in her fifties told her hospitalized husband how much she loves and is attracted to him. She recognized his contributions to their life together and to his profession. She also described how he was drinking

continuously, no longer accomplishing things, and making her life with him intolerable. She said how very much she wants to continue in their marriage, but emphasized there will be no room for alcohol. She proposed he accept three months of treatment and sober living as a prerequisite to returning home.

For additional information, see NCADD Alcohol Awareness Month and NY Times Topics

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