challenge could now be made to leaders in the alcohol treatment field in the United States. Low-risk drinking outcomes are a documented pathway to recovery in the United States as in other countries. Importantly, having moderation services available could facilitate such recoveries. Yet, advocacy for such services, even by government agencies, is virtually non-existent. Although it could be argued that the National Institute on Alcohol Abuse and Alcoholism has advocated for drinking reduction goals in primary care settings, such recommendations have been limited to those who are not alcohol dependent. The Dawson *et al*. study, in contrast, focused on thousands who at some point in their lives met diagnostic criteria for alcohol dependence. National initiatives to provide moderation services for people whose problems are not severe but who meet the criteria for alcohol dependence should be a public health priority.

In the remaining space, we outline what might constitute appropriate services:

1 Public information and education showing that recovery from alcohol problems without treatment is not only possible but also frequent. Such a strategy would increase the number of people attempting to change on their own, and also the number who succeed. For those who are not successful the attempt may increase their readiness to seek help, a finding demonstrated in a recent community-based mail intervention [6].
2 Government funding to provide moderation services and to further study alternatives to abstinence. This would have the advantage of attracting people with less serious alcohol problems to treatment, which in turn would broaden the base of treatment services [7].
3 Training health-care providers and addiction counselors to competently provide moderation services. Because many counselors in the United States have strong ideological biases against moderation goals, and because training in moderation services is not usually a part of one's career training, it is not realistic to expect such counselors to provide moderation treatment competently without training.

As shown in several studies, including that by Dawson *et al.*, many people with alcohol problems can and do succeed at reducing their drinking to low-risk levels. It is time for alcohol treatment providers in the United States to bridge the gap between research and practice by tearing down the wall. Such an expansion of services is necessary if we are to address comprehensively the needs of individuals with alcohol problems.

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STILL DIFFICULT TO KNOW WHAT ALCOHOL DEPENDENT INDIVIDUALS CAN RETURN TO CONTROLLED DRINKING: COMMENTS ON DAWSON *ET AL.* (2005)

Dawson *et al.* (2005) address a central question in alcohol research, the long-term outcome of *Diagnostic and Statistical Manual* version IV (DSM-IV) alcohol dependence in the general population. While prospective research is the preferable method to address this question, as they acknowledge, the authors used the very best retrospective data available, the 2002 NESARC. The sample size and richness of the variables allows many important predictors and outcomes to be addressed, including their very informative breakdown of the outcome categories.

The analyses are largely descriptive, leaving the development and testing of hypotheses to explain the findings for further work. Some predictors of the outcome of dependence that have been examined prospectively were not addressed, such as the presence of alcohol withdrawal, which predicts poor outcome of DSM-IV alcohol

dependence in community residents (Hasin *et al.* 2000), and in relatives of alcoholic patients (Schuckit *et al.* 2003). The frequency of binge drinking (5 + drinks) *per se* also prospectively predicts poor outcome in community residents with DSM-IV alcohol dependence (Hasin *et al.* 2001). The weakness of family history in Dawson *et al.*'s paper may be due to inclusion of distant relatives; considering only first-degree relatives may reveal an adverse effect, as it did in the alcohol-dependent community residents (Hasin *et al.* 2001).

Loss from a retrospective general population sample can also occur due to recall or reporting failures of past dependence, potentially introducing some bias. Our long-term follow-up of the community residents (Hasin & Liu 2003) indicates that some respondents who had earlier reported alcohol dependence at a 1-year follow-up failed to report the occurrence of dependence during this time when asked about it at the 10-year follow-up. As rightly noted by Dawson and colleagues, Wave 2 of the NESARC will provide an unprecedented opportunity to examine predictors of chronicity and recovery prospectively without the potential for such bias. Despite these caveats, however, the paper by Dawson *et al.* is exemplary in the overall methods of the study and the care and ingenuity with which the informative outcome categories were created.

A very important result of Dawson *et al.*'s paper is that full remission from the symptoms of DSM-IV alcohol dependence can occur among individuals who continue to drink. At one time, this finding would have been revolutionary. Fortunately, our field has matured enough so that is no longer the case. However, we remain without guidelines concerning who really must stop drinking in order to recover from DSM-IV alcohol dependence, and who can recover stably from dependence even while drinking moderately. While many guidelines exist on *how* to cut down or stop in terms of psychological (e.g. motivation, cognitive planning) and environmental changes (new peer groups, avoidance of cues for binging), however, these do not address the question of abstinence versus controlled drinking. It is possible that the integration of biological findings with recommendations for change attempts may make such recommendations more informative. It is possible that, eventually, the recently replicated findings on GABA(A) receptor polymorphisms as strong predictors of risk for alcohol dependence (Covault *et al.* 2004; Edenberg *et al.* 2004) or other biological findings will extend to predicting longitudinal course of dependence once established, and could be integrated into psychological and environmental recommendations. Ideally, tests may become available that can be conducted in non-specialist settings that will provide accurate information to alcohol-dependent individuals who need to make important decisions about whether to stop entirely or attempt to moderate their drinking.

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RECOVERY FROM ALCOHOL DEPENDENCE: RESPONSE TO COMMENTARIES

The broad-ranging issues raised in these four excellent commentaries reflect concern with both how the results of this study (Dawson *et al.* 2005) will be interpreted, the limitations of a cross-sectional analysis based on self-report and the implications of the findings for providing moderation services. Dr Finney (2005) is concerned that lack of explicit caveats regarding the apparent negative association between treatment and recovery may be misinterpreted as suggesting that treatment offers no benefits. Limitations of space and the desire to include new