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prime

from Prevention Research Institute

Intentional empathy

looking in the mirror and finding discrepancies page 1

there is **NO** them, only US page 12

The value of thinking again page 3

prime language page 13

Wait... I heard that ... studies in ...the news

page 5

Intentional empathy

Looking in the mirror... and finding discrepancies.

Ejna Mitchell, *VP Programs, PRI*

My encouragement to us all is to judge others less, look inward more, explore our own discrepancies, and make changes that are consistent with our own values.

It's 8:00pm. I'm exhausted and driving home from a long meeting. I keep getting frustrated with the number of people I see on their phones while driving – talking, texting, filming! I mean, they are putting their lives and MY life at risk!

But in my hurry to get home, I have also been driving more than 10 mph over the speed limit and 1 - 2 car lengths away from the truck in front of me for miles. **Aren't I doing the same thing?**

We all have discrepancies, and it's always easier to see them in others. We often call these things "hypocrisy" – hearing, thinking, or saying things like "What a hypocrite!" all the time. Let's call it "discrepancy" for the sake of this article. It's helpful to look in the mirror at times and see where we might find discrepancy. This practice helps us strengthen our empathy muscle – one useful at home, at work, and in everyday situations. Specifically, practitioner empathy shows up again and again in the literature as an important factor for positive outcomes with our clients. Discrepancy is often based on what's familiar, how we perceive risk, and what we value most.

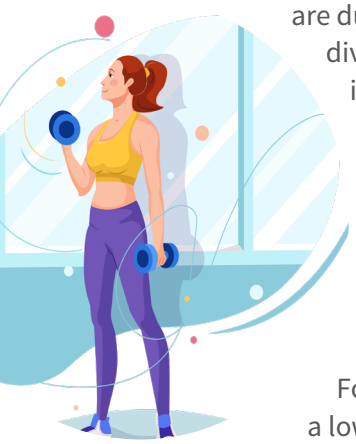
Let's start with familiarity.

If I am familiar with driving in my city, it often feels safe. I talk on my phone, speed, text at the red light, drive close to other cars, and it feels like no big deal. It's familiar. But what happens when I visit a new city? I'm in the unfamiliar now and tend to drive with more caution and notice others' driving patterns more. Risk is present in both cities. I feel it only in one of them. For our Prime For Life® and Prime Solutions® participants, alcohol and/or drugs are often the "familiar." We strive to let them see how it looks from a new perspective.

Next, let's think about how risk perception adds to the complexity.

I might get angry when someone is putting their kids at risk by not making them wear a helmet, or by providing alcohol in the basement to their teenager's friends. But I don't

think twice about letting my child swim in the lake without a life jacket or dive into the lake head-first in areas we can't see the bottom. There are different risk perceptions and different familiarities. Some parents think providing a safe environment for drinking is reasonable. The research doesn't support it, and we see myriad problems and tragedies as a result. And yet we can see why someone might choose this. We also know most lake drownings and injuries are due to either not having a life jacket or diving in shallow water. Risk is present in both scenarios, even when I don't personally perceive it.



Finally, our values are often indicative of our behaviors.

Sometimes they are aligned well. For example, I value health, and I eat a low-fat diet and exercise most days. Other times, our values and behaviors are discrepant. For example, I value family, and I spend more time on my electronics than I do with them. We most often have both - some behaviors that align well with our values and others that do not. As humans, we are sometimes okay with a bit of inconsistency. And sometimes we find out there are things we want to change once we become mindful of the discrepancy. This is what happens in Prime For Life, and it can be helpful in other areas of life too.

- **I might feel strongly about seatbelts in a car and yet eat a high sugar/fat diet.**
- **I might exercise consistently and yet make high-risk alcohol choices.**
- **I might complain people don't wear a mask and yet drive 80mph in a 65mph zone.**
- **I might wear a helmet on a bike and yet use THC regularly for pleasure.**
- **I might be against vaccines and yet get Botox injections.**
- **I might be afraid of large dogs and yet have pythons or other exotic reptiles in my house.**
- **I might complain about people using THC and yet use prescribed medication beyond the recommended dose.**

Life is full of choices. Sometimes daily risks - going up and down stairs or driving a car - seem like nothing. But what if we consider that over 1.3 million people die each year in car accidents world-wide (39,000 in the US) and over 1 million people are injured on steps every year just in the US? Puts the risk in perspective, doesn't it?

I have started using the handrail on my stairs! It's a choice I made based on a new level of risk perception. But I can't make that choice for others.

No one can make our choices for us. It's all on us! We do this based on what we perceive as risky, what we value, and, as we all know, a variety of additional social and psychological influences. For example, it's often more expensive to buy produce than high-fat foods. This social influence might affect my grocery shopping.

COVID is another great example of how risk perception predicts behavior. Most of us have made a change in our lifestyle due to this risk. According to the World Health Organization (WHO) 5.2 million people have died from COVID-19 in two years worldwide. Also according to the WHO, 3 million people die from alcohol causes every year worldwide. Surprising? When we focus on an issue it feels like the only issue. But there are always others, regardless of which has our attention and often the media's attention. What if the media spent two years focused on alcohol and drug issues - how many people are injured, get sick, become hospitalized, or die? It would change people's perception of risk. Social factors are strong influences.

Developing more awareness and understanding of addiction by increasing perception of risk is a primary goal of the first unit in Prime For Life. We also can benefit from more awareness in other areas of health and life that impact our dreams and futures.

My encouragement to us all is to judge others less, look inward more, explore our own discrepancies, and make changes that are consistent with our own values. I also suggest respecting others' liberty to have different values and make different choices. We don't have to agree with someone to show empathy. Typically, respecting people's freedoms instead of judging them can help influence better dialogue and less anger. We all have to determine how much risk we accept and the consequences of our choices. If I make a high-risk choice and it causes a negative outcome, that is my choice and my consequence. No one else can make it for me. I have to live with the outcome and others affected do as well. This is why it's often tragic.

continued bottom page 11

The Value of Thinking Again

David Rosengren, Ph.D, *President, PRI*

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There are multiple streams that feed this **rethinking river,** but one of the most important tributaries is a shift into a **scientific thinking mode.**

We are flummoxed when people fail to see things that are so obvious to us. Moreover, we see them persist in their beliefs when, if they would just look at the information carefully, they would surely see they're wrong. No, we're not talking about our clients. Nor are we discussing our political opponents. We're talking about **us** and how we get to this point.

Organizational psychologist Adam Grant (2021) explores these situations in his most recent book, *Think Again: The Power of Knowing What You Don't Know*. Among other things, Grant suggests two biases trip us up: A confirmatory bias where we attend to data that supports our position and ignore or discount data that disconfirms it, and a desirability bias where we see things as we want to see it. For example, as a Seahawks fan I only look at the data that support my belief the team is better than the fourth worst roster in the NFL – as rated recently by Bleacher Report. It is much more complicated than these two biases. For example, the less we know about something, the more we believe we know about it (Dunning Kroger Effect). **The worst part of it is we are often blissfully unaware of what we're doing.**

Are we then doomed to being blind to our misinformation and potential mistakes?

Or is there an antidote?

There is, indeed, an antidote. And it isn't tough love! The research studies, as well as our experiences, are clear: When pushed, we push back – just like our clients. Part of why we refute it might be that it doesn't match what we've read, seen, and heard – our sources of information. We might also have a little social dependence going on where we tend to affiliate with people who think and believe like we do, which reinforces our thinking. After all, I'm not hanging out with any 49er fans, for goodness' sake, who'd be more than happy to point out

continued top of next page

my team's shortcomings. They don't know what they're talking about.

To avoid these problems, Grant (2021) asserts we must be open to rethinking our position. There are multiple streams that feed this rethinking river, but one of the most important tributaries is a shift into a scientific thinking mode. To simplify, we begin with a model of how we think things work and make predictions based on these beliefs. However, we must retain a heaping plate of humility and a healthy dose of skepticism. This approach isn't just lip service. It is acknowledging we might be wrong and actively searching for reasons why that is so. Curiosity and discovery, rather than confirmation, are the attitudes we embrace. We look at not only our data but that of others and apply the SAME level of skepticism to both. Then we revise our opinions based on what we discover. At PRI, we express this process in a very simple manner: the data are always friendly. By this we mean the data will teach us something, perhaps including that we are wrong. It also leads us to play a little game we like to call "PRI Heresy."

PRI Heresy often, but not always, begins with something unexpected. Perhaps it is an instructor's experience or observation. It could be a journal article (or series of articles) that challenges a basic assumption. Sometimes it's staff learning something new through conferences, readings, or coursework. Regardless of how it arrives, it raises one of two questions: (1) What if we're wrong? and (2) What is the other, right way? My experience is the second question is a lot easier to contemplate than the first, but both are essential to consider.

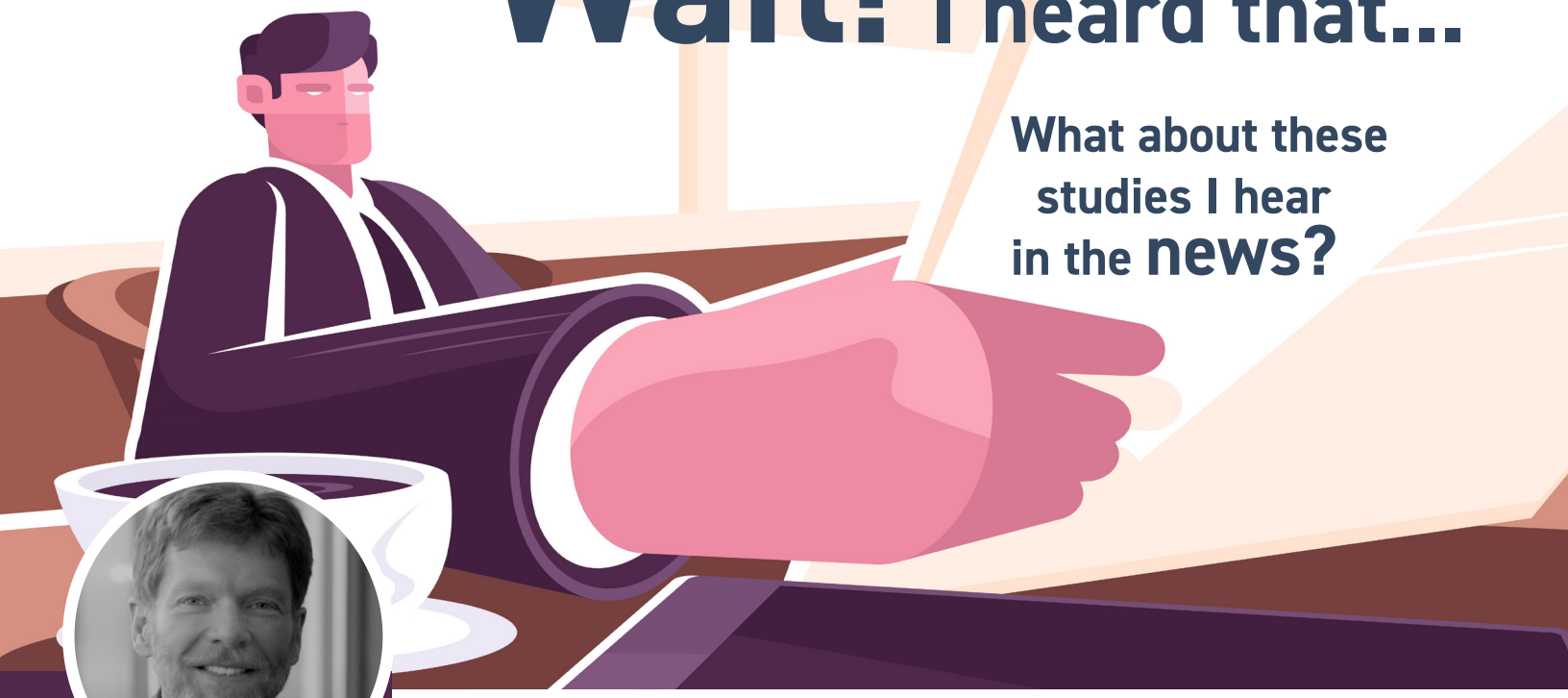
We've played a protracted game of PRI Heresy lately. Several research articles over the past six months asserted there is no low-risk amount of alcohol. These findings challenge a core feature of Prime For Life® – the Low-risk Guidelines – and require that we consider we might be wrong. Mark Nason began a careful review of the research and began forming questions. He consulted other researchers, including authors of the articles, and engaged in extended conversations about new techniques as well as the basis for their conclusions. The upshot is we've learned a lot about Mendelian Randomization (MR) – or, as Mark prefers, Genetic Instrumental Variant Analyses (GIVA) – as a method to predict risk levels, the assumptions it makes, the strengths it provides, and the limitations of the approach. After careful thought and discussion we concluded this research, at present, does not ask and answer the question of risk at particular levels of consumption as well as some other forms of analyses do. What do these three months of work mean for your delivery of Prime For Life? No change in what you say to clients, but perhaps a sense of assurance that we're minding the details, including our own tendencies towards bias. For more on this research, see Mark's article in this issue of PRIME titled "Wait! I heard that…"

As for my Seahawks, when applying the scientific method it seems I do need to rethink. The fourth worst roster sounds about right. They traded their starting quarterback, let their all-pro middle linebacker go, and chose not to re-sign their two offensive tackles. Their Pro Bowl running back will likely have to retire prematurely because of a neck injury and they're starting two unknown cornerbacks. Oh, and they've completely changed their defense. I'm thinking 5-12 record. Who is projected to have the worst roster, you might ask? Sorry Georgia folks – the Falcons have that ignominy. The good news? We all might have some extra free time on Sundays come Fall.

Reference:
Grant, A. (2021). Think Again: The Power of Knowing What You Don't Know. New York, NY: Viking.

Wait! I heard that...

What about these studies I hear in the news?



Mark Nason, *Research Analyst, PRI*

> “Oftentimes media outlets and some researchers draw conclusions from looking at **just one or two areas of research,** or solely at the newest studies.

I don’t know about you, but I run across headlines from time to time that indicate some of what we teach about alcohol in Prime For Life® (PFL) is no longer accurate.

More specifically, I see headlines opposing the idea that some low levels of consumption can be beneficial for some adults, and others going even further by indicating there is no “safe” amount of drinking for anyone.

Other times, there are headlines about studies affirming what we teach. **So, what’s the deal?**

First, and perhaps most importantly, in PFL we state, “Low risk does not mean safe. Low risk means there is little chance of harm or danger” (PFL e-manual, Scene 160). This is an important distinction. Even if research was able to prove there are benefits of low-level drinking for some people, this would not mean that level of consumption couldn’t harm others. Individual differences matter!

Still, you might wonder why we teach that adults who drink 1-2 drinks per day live longer than abstainers when much of the research highlighted in the media in recent years suggests otherwise. For example, at least one headline from March 2022 indicated the idea that low-level consumption can be beneficial has been disproven. It stated, “Harvard, MIT scientists slam door on studies showing ‘health benefits’ of drinking.”

This headline is very misleading. In short, when using traditional analyses, the study (Biddinger, 2022) cited in the news article found a protective effect for low-level alcohol consumption. However, when they used genetic instrumental variable analyses (GIVA), they found that starting at a “genetically predicted” consumption of about two drinks per week, there was a statistically significant increased risk for coronary artery disease (CAD) and some other forms of heart disease, and that these risks increase more dramatically with heavy consumption. Their estimates for when a statistically significant increased risk for mortality from all causes combined occurred ranged from a

continued top of next page

genetically predicted consumption of about 5 to over 17 drinks per week.

The authors of a review of studies using GIVA to examine the relationship between low-level alcohol consumption and heart health (van de Luitgaarde, 2021), concluded studies using GIVA have not answered the question as to whether there are amounts of drinking that could be beneficial. Though published after that review, the Biddinger (2022) study shares many of the same limitations listed in that review. Likewise, Biddinger and colleagues listed several significant limitations of their study in their journal article. In addition, their use of the words "may" and "suggest" when stating their conclusions also indicates their study does not provide a definitive answer. **For details on this study, see page 7.**

As with the Biddinger (2022) study, all other studies we have examined which suggest there is no benefit from any level of alcohol consumption (and/or that all levels of consumption increase risk) have as significant or more significant limitations as the studies suggesting the opposite. Over the years, we have examined many hundreds of studies on this. While new research methods are touted by some researchers as being better than previous methods, this is not always the case. In addition, new studies with improved methods which suggest possible benefits have sometimes gotten little-to-no media attention. This could be because they might not seem as newsworthy since studies have been indicating possible benefits for the past 40 years or so.

For example, another recent study (Ma, 2021) using the UK Biobank sample found lower risks among persons who consumed between 3.5 and 21 drinks per week, if they consumed alcohol on 3 or more days per week and consumed the alcohol with meals. This study has two major advantages over most other studies. First, analyses were done by different patterns of drinking, thus separating out people who drank the same average amount of alcohol by their frequency of drinking. This is important since people who averaged 14 drinks in a week and who drank 5 days per week would have usually consumed less than 3 drinks per drinking day, while those who averaged 14 drinks per week who drank on just 2 days per week would have consumed 7 drinks per drinking day. Second, consumption of alcohol with food significantly reduces the peak blood alcohol level a person reaches. This second factor has only rarely been included in studies and, to our knowledge, neither of these two factors have been included in studies showing no benefits and/or increased risk at all levels of consumption. Both factors affect risk and need to be considered regardless of method of analysis.

Nevertheless, the Ma (2021) study has significant limitations, too. For example, people were only asked about their "usual" average weekly consumption. Since many people vary their consumption, sometimes considerably, this measure inadequately considers the risk introduced by occasions of larger levels of consumption that people do not consider to be their usual level. It is likely that inclusion of measures of higher peak levels of consumption would have strengthened the evidence that lower quantities might have beneficial effects for some people. Conversely, even though the researchers controlled for a lot of potentially confounding variables, this study cannot rule out the possibility that uncontrolled factors which positively affect health might disproportionately occur among people who have a more favorable manner and pattern of drinking. So, it is possible that some or all the reduced risk among lower-level frequent drinkers was due to these uncontrolled factors. **For details on this study, see page 8.**

Notably, we have never seen any study examining risk for health problems or longevity which included information about speed of consumption. This, of course, is another key factor affecting risk from drinking. Faster drinking might also help explain the results of some studies showing significant increased risk (particularly for impairment problems) even at low average levels of consumption.
A study published in July of 2022 also shows potential benefits of low-level alcohol consumption for some age groups (GBD 2020 Alcohol Collaborators, 2022). **For details on this study see page 9.**

This study is very similar to one published in 2018, which suggested there is no benefit from drinking low-levels of alcohol (GBD 2020 Alcohol Collaborators, 2018). [See the Fall 2018 Prime Times for a review of that study.] The biggest difference is the new study provides separate analyses by sex and age group within each world region. More specifically, data is provided by sex, 5-year age group (for ages 15 and older), and year for 204 countries and territories.

Briefly, this study found drinking choices in the US which were associated with the longest lifespan and least years of disability ranged from 0 to one half of a drink per day—depending on the age group—with an increase in the

continued on page 10

Biddinger Study from page 6

Details about Biddinger study:

The following are some details about this study, which was touted by some media as proving that alcohol in any amount is not beneficial.

This study primarily involved 371,463 men and women out of the over half a million who participated in the UK Biobank—which includes demographic, behavioral, genetic, and other biological data. The researchers found a reduced risk for coronary artery disease (CAD) for those consuming up to about 10 drinks per week and no increase in risk until somewhere above 21 drinks per week when they used conventional epidemiological analyses. However, when they used genetic instrumental variable analyses (more commonly, though perhaps imprecisely, referred to by these authors and many others as "Mendelian randomization") they found that starting at a "genetically predicted" consumption of about two drinks per week, there was a statistically significant increased risk for CAD and some other forms of heart disease, and that these risks increase more dramatically (curvilinearly) with heavy consumption.

Genetic instrumental variable analyses (GIVA) of risks for CAD and hypertension by sex (the only two outcomes for which they report these analyses), though, failed to find statistically significant increased risk for either condition among women at any level of consumption. However, among men, they found a statistically significant 74% increase in risk for CAD and a statistically significant 39% increased risk for hypertension among men who consumed between >0 to 8.4 drinks/week, compared to abstainers. The increased risk was 75% among those who consumed between 8.4 to 15.4 drinks/week, 125% for those who consumed between 15.4 to 24.5 drinks/week, and 560% for those who consumed more than 24.5 drinks/week.
So, which results are correct? In our view, neither traditional analyses or GIVA gives us "the answer." Studies using traditional analyses have significant limitations, but so do alcohol studies using GIVA. Two of the major limitations of studies relying on conventional analyses are that they only use self-reported drinking choices, and they can never fully account for all the potentially confounding variables that can affect heart disease risk, which occur differentially by drinking level. For example, lifelong abstainers tend to have a lower exercise/activity level than drinkers, and lower exercise/activity level affects risk for heart disease. In theory, studies using GIVA control for differences in all possible variables that could affect heart health. That is, in these studies it is assumed all variables that affect heart health occur randomly among people with specific genetic makeups associated with different levels of alcohol consumption. This assumption of randomization has been called into question by some researchers—which is why they recommend the use of the term GIVA instead of MR (Mukamal, 2019).

In this study, the primary genetic instrumental variable used to predict alcohol consumption consisted of a combination of 5 genetic variants associated with having an alcohol use disorder (AUD) and the secondary analyses involved 10 genetic variants associated with score on the AUDIT-C (comprised of three questions about drinking choices). Importantly, as the authors acknowledged, the genetic variants associated with AUD are "… an indirect measure of alcohol use…" and "…the AUDIT-C questionnaire is also designed to screen for heavy alcohol consumption rather than habitual alcohol consumption." They went on to say "…future assessments testing our genetic instruments—as well as others for continuous alcohol consumption—in additional, large genetic data sets will be of importance" (p. 9).

Using complex statistical modeling, the researchers assigned a drinking level to each person based on the person's genetic makeup. While the level of drinking for any particular combination of these genetic variants was calculated from the self-reported drinking of groups of people, unlike in conventional analyses, the level of consumption an individual was predicted to have was not based on that individual's self-reported drinking level. No matter how well this statistical modeling is done, error will occur, and the degree of this error was not specifically addressed in the journal article. [Months ago, I emailed the corresponding author twice to ask about the degree of error this modeling would introduce, along with other questions, but have yet to get a reply.]

In supplementary online materials, the researchers also included two graphs showing estimates on the number of genetically predicted drinks consumed per week that were associated with increased risk for premature mortality, using two different types of statistical analyses. The two estimates were very different. One indicated statistically

continued top of next page

significant increased risk started at a genetically predicted consumption of about 5 drinks per week, while the other showed a statistically significant increase in risk did not occur until a genetically predicted consumption of somewhere above 17 drinks per week. No indication was given as to whether one of these types of analyses was better than the other. Also, the only reference to this mortality data was the following statement: "Furthermore, increased alcohol consumption was associated with increases in disease risk that were exponential and unequal in magnitude, even when comparing light and moderate levels of consumption (i.e., between 1 and 2 drinks per day). Similar trends toward nonlinear and single-directional (i.e., quadratic) associations were noted for other cardiovascular diseases and for all-cause mortality (eFigures 6 and 7 in the Supplement)" (p. 6).

For more details about GIVA and its limitations, and for a discussion of all areas of research on the issue of whether low-level drinking can be beneficial to some people, see "Can drinking alcohol be beneficial to some people?".

Details about Ma study:

This study included 155,372 drinking men and 161,255 drinking women, aged 37 to 73 years, from the UK Biobank study, followed for a median period of 8.9 years. Lifetime abstainers and former drinkers were excluded in most analyses because lifetime abstainers tend to have a lot of differences from drinkers that could negatively affect lifespan and many former drinkers quit drinking due to having an AUD or other health problems (many caused by their drinking). In addition to asking about the usual amount people drank, they asked about how many days per week participants typically drank and whether they drank with meals. Those who consumed alcohol on 3 or more days per week and always drank with meals were classified as having a favorable pattern and manner of drinking. Those who consumed alcohol on 2 or fewer days per week and/or sometimes or always drank outside of meals were classified as having unfavorable drinking.
For men and women combined, and in sex-specific analyses, statistically significant increased all-cause mortality risk was not found until somewhere above 21 drinks per week. The exception was among women with "unfavorable" drinking scores, who showed statistically significant increased risk somewhere above 14 drinks per week.
Risk for mortality from all cancers combined was also found to be related to pattern and manner of drinking, not just quantity of drinking. After adjusting for several potentially confounding variables (age, race, location of assessment, body mass index, level of physical activity, smoking status – never, past, or current, a healthy diet index, Townsend deprivation index, and preexisting diabetes, hypertension, and high cholesterol), compared to women who consumed less than about 3.5 drinks per week, women at all higher levels of consumption who had a favorable pattern and manner of drinking showed no increase in fatality from all cancers combined. However, among women with an unfavorable manner and pattern of drinking, there was a statistically significant increased risk for death from all cancers combined at a usual weekly consumption level above about 21 drinks.

In addition, compared to women who consumed up to about 3.5 drinks per week and drank on two or fewer days per week and/or drank outside of meals (sometimes or always), women who drank at least 3 days per week and consistently ate when drinking showed a statistically significant decreased risk for all-cause mortality at a weekly consumption level of about 14 drinks. Similar results were found for men.

More specifically, controlling for weekly alcohol intake and other variables (including sex), drinkers who consumed alcohol on three or more days per week and consistently ate when drinking had a statistically significant 18% lower risk for dying from all causes combined and a statistically significant 18% lower risk for dying from all cancers combined compared to those drinking less often and not consistently eating when drinking. Thus, the data in this study suggest that risk for all-cause mortality and increased risk for mortality from all cancers combined is linked to pattern and manner of drinking even more than to averaged quantity of usual drinking and is likely to be largely confined to men and women who exceed one or more parts of the low-risk guidelines taught in PFL.
In analyses using a genetic risk score (GRS; based on 90 genetic variants associated with alcohol consumption), Ma and colleagues found a more favorable pattern and man-

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ner of drinking was significantly associated with a lower risk for premature mortality independent of the GRS for the amount of alcohol consumed. This suggests that when pattern of consumption and whether alcohol is consumed with meals are considered, genetic analyses sometimes also show a protective effect from low-level alcohol consumption.

Surprisingly, the lower mortality risk for men and women who drank more frequently and with meals was stronger among those with a lower economic status than those with a higher economic status. This is significant because many critics of the research showing health benefits from consuming 1-2 drinks per day have suggested that the findings of benefit are confounded by SES. That is, they believe that uncontrolled differences among higher SES drinkers explain the longer life rather than the low-level drinking.

Details About GBD 2020 Alcohol Collaborators (2022) Study:

This is largely an update of the GBD 2016 Alcohol Collaborators (2020) study. Researchers examined data from 204 countries and territories on alcohol consumption, as well as mortality data and years of disability among ages 15 and older. Estimates of average daily consumption of alcohol were calculated from a combination of sales data revised for tourists' consumption and unrecorded consumption from illicit sales, and self-report consumption data. The self-report data was rescaled to fit with estimates of population-level consumption. Risk estimates for 22 health outcomes (including self-harm and traffic crashes) were based on a meta-analysis of data from 592 studies.

Unlike the previous global study, levels of consumption associated with the best outcomes for mortality and disability and the level of consumption that carries the equivalent risk as that of non-drinkers are provided by region, sex, and age group. Results for both measures varied significantly by age group and region, but not sex.

Unfortunately, the researchers did not indicate the level of drinking that was associated with having a statistically significant greater risk than abstainers. That is, while about 2 drinks per day was the NDE for ages 65-69, it might be that a statistically significant greater risk than abstainers does not occur for this age group until over 3 drinks per day.

One of the biggest limitations listed by the researchers was the lack of data on pattern of consumption. They also mention that the relative risk estimates used did not account for all sources of bias.

Key findings for the US, and overall conclusions include: [Please note the number of drinks listed below are different from those in the journal article. This is because they are based on 14 grams of pure alcohol per drink—which is the definition used in the US and in PFL—while the researchers in this study defined a standard drink as 10 grams of pure alcohol, which is a common definition worldwide.]

- Among males, there was no evidence of potential benefits from drinking until ages 25-29, and this was for an average of one-tenth of a drink per day. This increased with age, to a peak of an average of one-half of a drink per day for ages 80 and older.
- Among females there was evidence of potential benefits for all age groups 15 years and older. This ranged from one-tenth of a drink per day among ages 15-19 to an average of one-half of a drink per day for ages 80 and older.
- Nevertheless, there were no statistically significant differences by sex in any age group in any region worldwide. Accordingly, the authors propose that drinking guidelines be the same for women and men.
- The level of alcohol consumption that showed the equivalent risk as that of a non-drinker (NDE) ranged from 0 among ages 15-19, to 0.4 standard drinks per day for ages 35-39, to over 3 standard drinks per day for ages 80 and above.
- In the US and worldwide, young males had the greatest risk for premature mortality and more years of disability from consuming alcohol—due to their having a greater likelihood of consuming larger amounts of

continued top of next page

alcohol per occasion and experiencing impairment problems.

- Regarding the issue of potential beneficial effects from drinking, the authors conclude, "the relationship between moderate alcohol use and health is complex …Given that the available evidence suggests that low levels of alcohol consumption are associated with a lower risk of some disease outcomes and an increased risk of others, alcohol consumption recommendations should take into account ...the background rates of disease within populations" (p. 224).

Given the high rates of CAD and type 2 diabetes in the US and the evidence of a protective effect of low-level consumption on risk for these conditions, the researchers' conclusion listed above suggests to us the possibility that low-risk guidelines could be higher in the US than in some other countries.

Wait, I heard that...from page 6

amount of alcohol which might be beneficial as age increases. In addition, they calculated the drinking choices that carried the equivalent risk found among non-drinkers (NDE). The NDE in the US ranged from 0 to over 3 drinks per day, depending on the age group. The NDE also increased with age. One of the major limitations of this study, like the similar one in 2018, is that it did not account for pattern and manner of consumption—as was done in the Ma (2021) study. Thus, if the indication of a protective effect at some ages is correct, then people who consistently drink low quantities also consume alcohol slowly with meals, this protective effect would likely occur at larger quantities than indicated in this global study. Nonetheless, other limitations prevent the findings from this study from being proof of a protective effect.

Of course, there are many more studies, recent as well as older, relevant to these issues. Below is a summary and conclusion of our examination of whether low levels of alcohol consumption might have some benefit for some people.

Oftentimes media outlets and some researchers draw conclusions from looking at just one or two areas of research, or solely at the newest studies. We based the following summary and conclusions on our assessment of findings from hundreds of studies—across many types of research—conducted since the mid-1970s. Does this mean we have "the answer"? No, unfortunately the scientific evidence is not that conclusive. There is certainly room for people reading the same research to reach different conclusions. Nevertheless, we suggest that when definitive statements are made about either low-level alcohol consumption being beneficial or any level of consumption being harmful, such statements are likely based more on bias than on a good understanding of the existing science.

Observational studies have typically found statistically significant and meaningful correlations between consuming one half of a drink to two drinks per day and lower risk for coronary artery disease and type 2 diabetes, better overall health, and a longer lifespan. Most studies using GIVA suggest these correlations are not causal. Controlled studies with humans indicate this pattern of drinking leads to positive changes in high density lipoprotein cholesterol, fibrinogen levels, and some other biomarkers of health. Laboratory and other studies have provided explanations as to how alcohol positively affects these biomarkers, and animal studies have demonstrated positive changes in biomarkers of health and some evidence of increased lifespan in some animals given small doses of alcohol. Although all studies have limitations and not all studies show the same results, research as a whole offers significant evidence—though certainly not on the level of proof—that consumption of one half of a drink to two drinks with a meal on a daily or nearly daily basis can have some health benefits and prolong life for some people. Nevertheless, some studies indicate this low level of alcohol consumption might result in negative outcomes, such as a small increase in risk for some types of cancer in some men and women. So, while it seems likely that low-level alcohol consumption could be beneficial to some, frequent consumption of low levels of alcohol could be harmful to others. In PFL, we teach low-risk guidelines, not "no risk" guidelines, and we do not make a recommendation for people to drink alcohol in order to be healthier or live longer. This type of advice is best reserved for an informed physician or other healthcare provider who can help individuals consider their current health status, health history, family's health history, and their history around problems with alcohol or drugs. For a more detailed look at

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Wait, I heard that...from page 10

this subject, see "Can drinking alcohol be beneficial to some people?".

Also, if you are interested in details on research on cancer risk within the low-risk guidelines, see "Low risk is not 'no risk': Cancer risk associated with drinking within the low-risk guidelines" in the same location on the Dashboard.

Please contact me if you have any questions about alcohol research:

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Intentional Empathy...from page 2

One thing I know for sure is that while making low-risk choices can be hard at times, it's much easier than experiencing the tragic outcomes of high-risk choices. My daughter is an ICU nurse and there is a common theme in the ICU: no seatbelt, no helmet, no life jacket, high-risk drug choices, high-risk alcohol choices, high BMI, neglect, abuse, and not following medical plans. Just because I don't feel at risk doesn't mean I'm not at risk. We are all one choice away from tragedy. AND we are all one choice away from protecting our future. What will you choose? What do you want to protect so you can meet your own life goals?

For me? I am going to start exercising more consistently and decreasing my technology usage.

While we can't prevent all problems, and life has many accidents and unintended outcomes, being more intentional about what we can do can be lifesaving. Save the high-risk choices for those choices that are calculated. Start the business, ask for the promotion, go back to school, learn a new skill, ride the Harley, race the car (on a track), sky dive, or dance. For those who are sensation seekers this is an important part of life too. Calculated risks are inherently different because we train and prepare for those.

There is no them...only US

David Rosengren, Ph.D, *President PRI*

I was listening to a podcast with the documentarian Ken Burn recently. In considering his films – "The Civil War," "Baseball," "The War," "Jazz," "Vietnam," "The National Parks," and "Muhammed Ali" to name just a few – he offered there is a question at the core of them: **Who are we as Americans?** He notes that each movie catches a part of the answer, and perhaps helps us to locate ourselves in this moment and time. It also leads him to the conclusion, there is no them, only us.

I just can't let go of this idea. It's nestled inside of my head and won't leave. Of course, there are all the familiar refrains singing there is a them and harmonizing around difference. Indeed, there are social psychologists who have studied our tendency to place people into groups who argue this is an evolutionary process, set deep in our genes and designed to keep our tribes safe. Is biology destiny? Our model says "no" for a good many things. Perhaps for this, too.

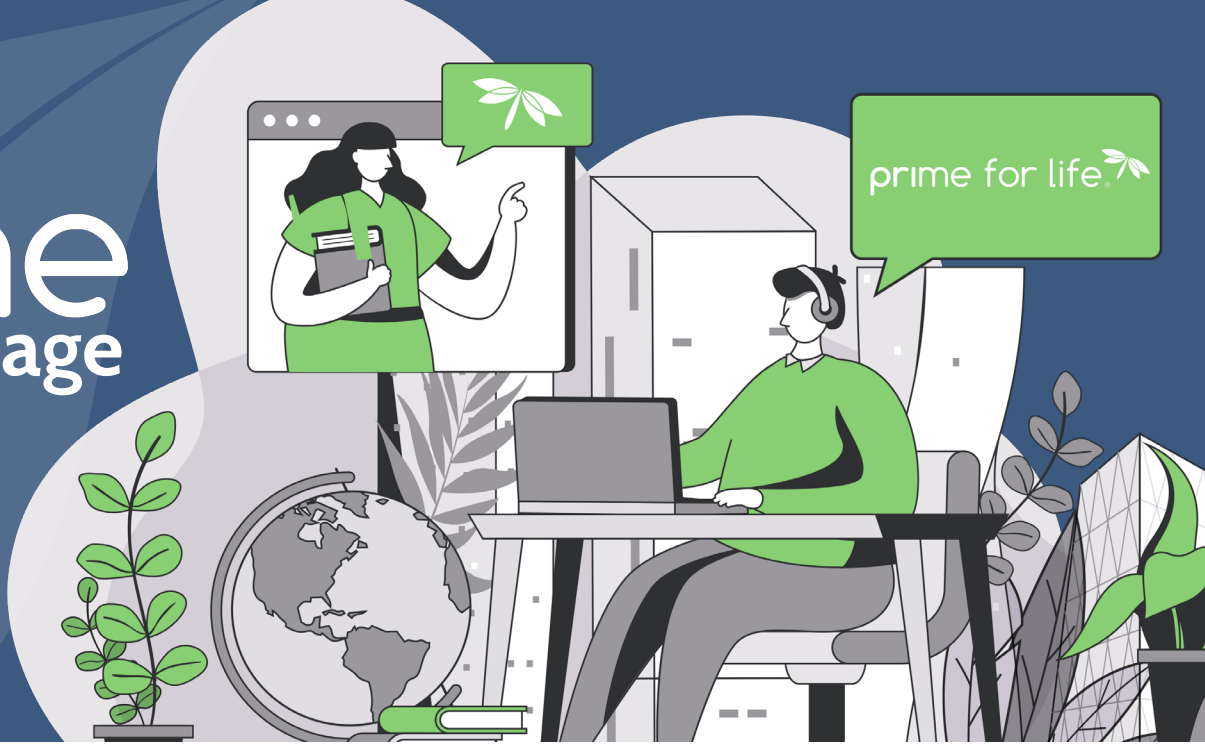
It makes me think about the people we work with and returns me to the Like-Like Rule. Stated simply, we like our clients and students, and we are like them. We recognize ourselves in them, and we seek to connect genuinely. This is not easy and requires us to cultivate a curiosity about who this person is. What would it mean to our work if we viewed that disengaged, challenging person as one of us?

Ken Burns attributes to Mark Twain that history doesn't repeat itself, but it does rhyme. What a beautiful turn of phrase. He is right, and he might need to go further, "…it does rhyme if we make the same choices."

There is no them, only us. It feels like this idea isn't going anywhere and it feels like it has power. What would it be like to constantly live into that idea? I don't know, but I intend to try. Care to join me?

> "History doesn't **repeat itself,** but it does rhyme... if we make the **same choices.**

prime Language



Michelle Stephen Seigel, *Training & Development Mgr, PRI*

When the conduct of men is designed to be influenced, *persuasion*, kind, unassuming persuasion, should ever be adopted.

– Abraham Lincoln

Guess how many words are in Prime For Life?

In the 20-hour version it's usually more than **65,000; more than 85,000 if we include the endnotes** (which is why they are endnotes—if we were to share all of them, we would have a much longer program!). When we consider other interactions in a group, **this amounts to a LOT of talking.** And all this talking – all these words – matter.

A new instructor contacted me recently with curiosity about the recommended language in Prime For Life. The question regarded why we coach on avoiding words such as "healthy/unhealthy, right/wrong, good/bad, safe/unsafe" and, instead, encourage the phrases "Low Risk/High Risk choices." To support her I turned to the almighty PRI Research Team - specifically Mark Nason, who is often referred to as a "walking encyclopedia" of all things Prime.

Mark immediately responded with a barrage of citations that he keeps close to his heart in a pocket with his pens and glasses. His response reminded me of a Version 9 program development meeting in 2012 where we sat in a room for DAYS, often deliberating the nuances of a word and the meaning it might carry to the ears and heart of a participant. This is a tradition at PRI, going back to the 80's when Ray Daugherty and Terry O'Bryan created the first version of Prime For Life — Talking with Your Kids About Alcohol (TWYKAA).

They crafted the Lifestyle Risk Reduction Model in a climate where educational and treatment programs embraced confrontation and information sharing as primary strategies, and they had the courage and insight to envision another way. Instead of confrontation — engagement. In lieu of "information overload" – carefully sequenced content shared purposefully and in a way that allows instructors the freedom to be genuine and use words and phrases meaningful to them and their participants.

Ray and Terry were moving in a unique direction reviewing persuasion research. Ray recently shared with me on a Zoom call dedicated to this topic, "It became clear anything

that provokes resistance or thoughts in the other direction, or judgment, works against change." The words we choose matter, particularly as clients experience new information about risk related to their choices.

Our Prime Language reflects the "central" route to persuasion. It's deliberate, often subtle, and designed to engage participants and avoid provoking defenses which can create barriers and disengagement. This approach allows participants to relax into Prime For Life and offers space to reflect and share when they are ready.

Ray mentions a little more about this in the book he wrote with Carl Leukefeld, *Reducing the Risks for Substance Abuse: A Lifespan Approach*. Touching a person emotionally or logically requires touching both the head and the heart, while working to defuse beliefs and defenses that persist related to the high-risk behavior.

How does Prime Language fit with our role of sharing content that might not align with what participants believe and, more importantly, LOVE?

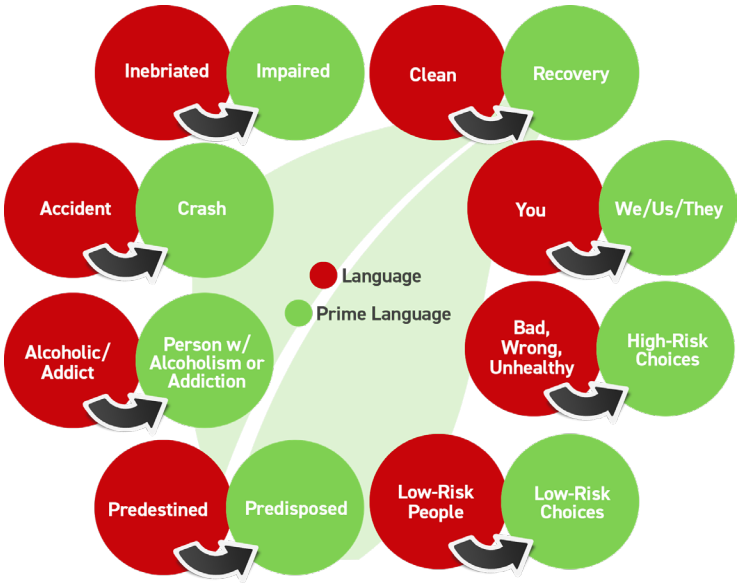
When facilitating Prime programs, we serve as a conduit of the Prime spirit. Our PRImary tool (see what I did there?) to express both content and process is language.

Ray has been sharing a CES session on Prime Artistry and notes each artist has a set of tools. Perhaps our most powerful tools of influence as instructors and counselors are the words we choose when sharing Prime For Life and Prime Solutions®.

So back to where we started—consider how, to a Prime For Life participant, "good or bad choices" feels different than "low risk or high risk choices." "Good or bad" carries judgement and may engage dissent — even subtly, this can build to disengaging from the process of the program.

> *"The process of putting your focus on language is only the first step. How you do that is at least as important. Using your own voice, your own examples, your common ground with the client will make that focus alive and fresh. Don't be afraid to bring your unique way of thinking and speaking into your delivery."* – **Theresa Moyers**

Here are a few more words and phrases shifts to consider:



Lincoln might have said it best addressing the Washingtonian Temperance Society: "When the conduct of men is designed to be influenced, *persuasion*, kind, unassuming persuasion, should ever be adopted."

As Prime providers, it's not OUR cause. The "cause" is to share content with impact and empathy and allow participants to envision, and later plan for, a future where their values are alive and thriving and continuing to grow in a direction they desire.

> *"Therein is a drop of honey that catches his heart; which, say what he will, is the high road to his reason, and which, once gained, you will find but little trouble in convincing his judgment of the justice of your cause, if indeed it is a just cause. On the contrary, attempt to dictate to his judgment, or to command his action, or to mark him as one to be shunned and despised, and he will retreat within himself, close all avenues to his head and his heart, and though your cause be naked truth itself, transformed to the heaviest steel, ... you will no more be able to pierce him, than to penetrate the hard shell of a tortoise with a rye-straw. Such is man, and so must he be understood by those who would lead him, even to his own best interests."* – ***Abraham Lincoln***

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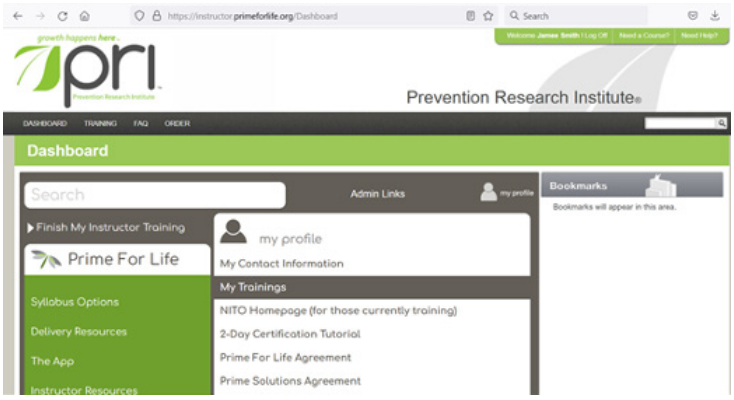

- **Visit www.primeforlife.org.**
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- **Log into your Dashboard using the email address you use to register for CE sessions and your password.** ***(If you've never changed your password, it is "changeme"; if you have changed it and can't remember, use the password recovery option.)***
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We hope you find this new Dashboard feature helpful! As always, we are here to offer assistance when needed. Please contact support@primeforlife.org with any questions!

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