

Addictions

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Treating Alcoholism

Alcohol misuse is a major public health problem. Consumption of alcohol in the UK doubled between 1950 and 1980 from five litres of alcohol to ten litres per head per annum and has since plateaued. Even higher consumption seems likely if harmonisation of alcohol prices continues in the EU.

In turn, the costs of alcohol misuse are now in excess of £2.5 billion per annum.¹ Alcohol contributes substantially to 40,000 deaths per year,² and about one-third of all premature deaths in middle-aged men are now alcohol-related. In an average practice with 2,000 patients, 149 are heavy drinkers, 37 problem drinkers and 19 seriously dependent.³ Alcoholism affects people from all socioeconomic groups. Doctors are no exception approximately 50% of doctors referred to the GMC have an alcohol problem.

The belief that brief interventions are as effective as intensive therapy for, alcoholism has gained ground. Consequently, the last 15 years seen a closure of specialised inpatient units.

Nevertheless, the demand for intensive treatment remains high, reflected by the growth of treatment facilities in the private and voluntary sector.

Research from Scotland (Figure 1) shows that between 1980 and 1989, when admissions to psychiatric hospitals fell, there was a marked rise in discharges of patients from general hospitals with a diagnosis of alcohol abuse and dependence.

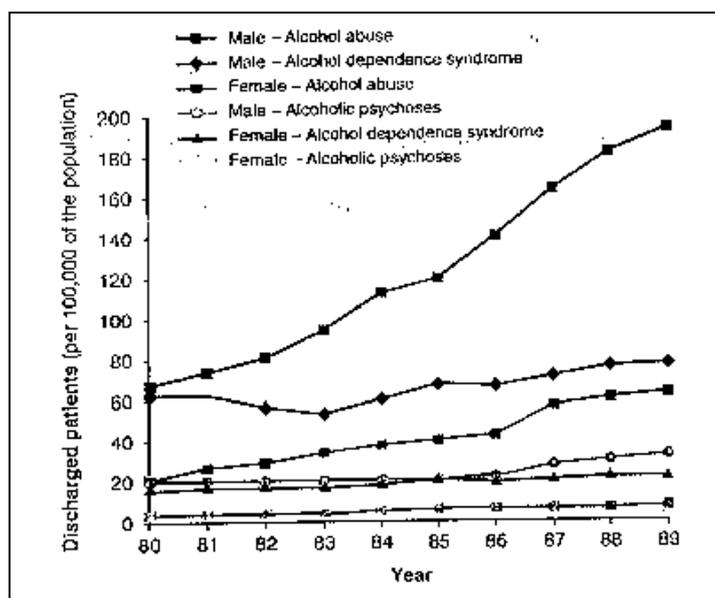


Figure 1. Discharge rates from Scottish general hospitals with a diagnosis of alcohol abuse or dependence

There was a doubling of discharges for alcoholic psychosis and almost twice the number of deaths from alcoholic cirrhosis.⁴ Between 1991 and 1995 there was a further 70% increase in discharges with alcohol dependence syndrome from non psychiatric hospitals (Scottish Office).

The recommendations of the Lord President's Report⁵ are therefore timely and relevant, This comprehensive government policy statement on alcohol misuse emphasises that, apart from the generic services, there is need for a comprehensive range of services with high, medium and low levels of care. Alcoholism is a destructive condition, but it is potentially treatable. Pessimism about the possibility of recovery often means that no intervention is undertaken at all. However, 50% of alcoholics can achieve stable recovery, and a significant number achieve stable remissions the first time they seriously seek treatment⁶ .

Defining alcohol addiction.

Addiction refers to a behavioural pattern of drug use characterised by compulsion, preoccupation and relapse⁷. The description of the dependence syndrome by Edwards and Gross (Table 1) was a landmark in the evolving concept of addiction.⁸ The syndrome consists of a cluster of cognitive, behavioural and physiological phenomena. These elements have been incorporated in the internationally used criteria for diagnosis of alcohol dependence, namely the DSM IV and ICD 10 systems.

The key feature of addiction or dependence Contained in these criteria are:

Impaired control indicative of compulsion there is a tendency to drink larger amounts over a longer period than planned and an inability to predict consumption consistently.

Relapse - a persistent desire or unsuccessful efforts to cut back, with recurrent inability to control consumption

Preoccupation - excessive attention is focused on acquiring and drinking alcohol. Alcohol occupies a central role in life and other activities are reduced.

Use of alcohol despite related problems alcohol is more important than the problems it is causing., It is easier to measure alcohol related problems than loss of control, and the link between such problems and alcoholism is high.⁶

Physical dependence - tolerance and a withdrawal syndrome are not necessary for a diagnosis of alcohol dependence. A heavy reliance on withdrawal symptoms may lead to a failure to diagnose serious dependence. Once dependence is established, continued drinking is very likely to cause significant recurring problems.⁹

Denial

The diagnosis of alcoholism can be difficult and the patient may appear uncooperative due to his denial of his problems. Defence mechanisms include minimising the extent of alcohol consumption and the harm it causes, rationalisation, grandiosity, blaming others and conflict avoidance. To gain a realistic awareness of alcoholism, and for recovery to begin, many of the alcoholic's defences need to be dismantled or redirected. This requires skill and expertise. The patient's characteristic blindness is linked to repressed fear, guilt, shame, remorse and low self-esteem. A heavy-handed approach may be psychologically damaging and cause overwhelming anxiety.

Diagnosis

The majority of alcohol-dependent patients are not detected in practice. To assist in diagnosis it is helpful to:

Know the common presentations of alcoholism (Table 2).

Use the CAGE (75% accuracy) (Table 3) and MAST questionnaires.³

Obtain a history of problems and relate these to alcohol abuse; then establish the quantity and frequency of consumption.

Assess the severity of dependence.

Perform a physical examination.

Request blood tests.

Obtain a history from an informant.

Alcoholism as an illness

Research indicates that alcoholism is a genetically influenced condition - genes interact with environmental factors to place a person at greater risk. Adoption studies indicate that sons of alcoholics have a three- to four-times greater risk of alcoholism. Most twin studies support a genetic contribution.¹⁰ Learning factors also powerfully shape drinking behaviour. Recent neurochemical research suggests addiction is due to neuroadaptive mechanisms in the brain that are not only responsible for physical dependence but possibly, also cause the repetitive desire to drink more.¹¹

Professor Edwards states that the alcoholic is 'certainly ill'.⁸ It is the involuntary and compulsive nature of the drinking, leading to serious harm, that makes dependence an illness. ¹² However, many still view alcoholism as a behavioural disorder, and drinking is seen as impulsive or deliberate, rather than addictive. The concept of alcoholism as an illness has the therapeutic advantages. The explanation that it is a serious but treatable illness reduces shame and defensiveness and conveys hope. The patient is helped to take responsibility for the management of a chronic and potentially fatal condition.

Table 1 Alcohol dependence syndrome

Table 2. Common presentations and risk factors of alcohol dependence

Narrowing of drinking repertoire

Salience of drink-seeking behaviour increased tolerance to alcohol

Repeated withdrawal symptoms

Relief or avoidance of withdrawal symptoms by further drinking

Subjective awareness of the compulsion to drink

Reinstatement after abstinence

Symptoms of anxiety, depression, stress, insomnia, interpersonal problems

A history of accidents

GI symptoms - eg, diarrhoea, gastritis

Hypertension

Erratic work performance

A high tolerance to alcohol

High-risk occupation

Family history of alcoholism

Table 3. CAGE questionnaire

Have you tried to or felt you should cut down your drinking?

Have you ever felt annoyed by criticisms about your drinking?

Have you ever felt bad or guilty about your drinking?

Have you had a drink first thing in the morning ('eye-opener') or before lunch to steady your nerves or get rid of a hangover?

Alcoholism symptom or primary condition?

Whether alcoholism is seen in terms of cause or effect will determine the approach to treatment. Many doctors view dependence simply as a symptom of underlying psychopathology - the person is seen to be self-medicating. The approach then becomes an attempt to treat the depression or neurotic disorder in the expectation that the drinking will resolve. However alcoholism is often a primary condition and the main cause of any psychological disturbance. 12

Case study

Jane, a 35 yearold upper-middle-class housewife mother of three, was admitted to hospital following an alcohol and benzodiazepine overdose. She gave a history of 'heavy social drinking' until 31 years old. Her control became sufficiently impaired that she drank almost daily during her pregnancy because she 'was unable to stop herself'. Between the ages of 31 and 35 she was treated for anxiety disorder by her GP and attended a psychologist for 18 months, She was treated for depression as an inpatient and outpatient and was prescribed antidepressants and tranquillisers.. But Jane continued to drink addictively and secretly - she experienced memory blackouts, abused benzodiazepines and suffered marital breakdown.

After specialised inpatient treatment for alcoholism chemical dependence, her depression and anxiety resolved without additional pharmacotherapy. She has been abstinent from alcohol mind-altering drugs for 11 Years and still attends Alcoholics Anonymous (AA). She enjoys many alcoholics an increasingly fulfilling personal and family life.

Treatment modalities abstinence - or controlled drinking?

Minimal intervention

Controlled trials have shown that minimal interventions, offering advice and facilitating reduction strategies, have been effective for stable mis-users of alcohol with brief histories.¹³ This is a sensible first step for those who are not dependent and without severe problems. For those who fail, and for the more entrenched drinker, other treatments will be required.¹⁴

Abstinence

The more stereotyped, repetitive and involuntary the drinking behaviour, the more difficult it will and be for the patient to return to moderate drinking. When the history shows failed attempts to control drinking, the more insistent we should be on the goal of abstinence.

An influential study conducted by Sobell and Sobell in the 1970s¹⁵ claimed success with controlled drinking of alcoholics. However, the results of this study were convincingly challenged by Pendery, who found no evidence that alcoholics could control their drinking.¹⁶ Follow up studies by Vaillant, then confirmed by Helzer, found that less than 6% of alcoholics maintained stable pattern of problem-free drinking.^{17,18} The patients who were successful usually had low levels of dependence and less pervasive problems.

Abstinence is the preferred goal for many alcoholics because over 95% are unlikely to achieve help the sustained control. Short periods of problem-free drinking are part of the natural history of alcoholism, but it is difficult to identify the possible 5% who can control their drinking.

Inpatient or outpatient?

Data support the effectiveness of outpatient treatment for uncomplicated alcohol-related problems where there is psychological stability. Since inpatient treatment is expensive it is generally reserved for severely dependent patients who fulfill some of the indicators in Table 4. In these cases inpatient care can be cost-effective

In a randomised clinical trial, outcome was studied over a period of two years for discharged patients.¹⁹ More achieved continuous abstinence with inpatient treatment together with AA (37%), compared with AA alone (17%), or a choice of options (16%). In terms of cost-benefit, the more costly inpatient treatment produced superior results. Furthermore, Shaw reported a 53% abstinent or improved rate at one year follow-up after inpatient treatment for severely dependent patients.²⁰ Finally, the CATOR registry reported that 63% of over 1,800 treatment completers were totally abstinent for one year with improved quality of life.²¹

Treatment strategies

There are many competing approaches but no single superior treatment. The abstinence-based illness strategy, - the 'Minnesota Model' - uses the principles of AA and is used widely in the USA and the UK. ²² It is common for an intensive approach to be adopted in the inpatient setting, involving drawing up a comprehensive treatment plan and using a multidisciplinary team trained - to treat addictions. Often some of the staff are recovered alcoholics who can act as role models and mirror the hope that stable recovery can take place.

Daily lectures and individual and group therapy address the dysfunction caused by addiction. The treatment effort is directed at motivating patients to commit to abstinence, improving their physical and mental health and helping them to rebuild a fulfilling life.

Medical evaluation

Approximately 80% of alcoholic patients have a coexisting medical problem - for example, hypertension, peripheral neuritis, pancreatitis, liver disease or cardiomyopathy. 23 Up to 50% inpatients have significant cognitive impairment due to cortical atrophy. Some 50% suffer from a psychiatric disorder such as depression, anxiety, phobic states or personality problems.

Such disturbance is often secondary to the drinking and resolves within four to six weeks after detoxification and abstinence, but the possibility of a coexisting primary psychiatric disorder must be considered.

Detoxification

Detoxification is normally with long-acting benzodiazepines (e.g., diazepam), which provide a smooth withdrawal, reflecting long half-life, and permit rapid reduction over the first 24-48 hours. Minor tranquillisers, which render alcoholic patients vulnerable to relapse or cross-addiction, should not be prescribed after detoxification.

Psychotherapy

The following principles are important.

The first and most essential step in treatment is to help the patient gain insight into the addictive process and their impaired control. Without this awareness there is unlikely to be an commitment to abstinence.

Table 4. Indicators for inpatient treatment

if the patient has a history of..

Failed outpatient treatment

Severely unstable or chaotic living conditions - family instability, few personal or social resources, the elderly

Current psychiatric comorbidity

Serious medical complications - threatening or existing
The patient requires:

Alcohol or drug detoxification

Intensive cognitive behavioural therapy

The whole person must be treated, with an awareness of the contributory factors to drinking that could precipitate relapse.

The cognitive/behavioural approach, which is directive and can be used in a group context, is most effective. More 'exploratory psychotherapy' at this stage produces intolerable anxiety and triggers the urge to drink.

Emphasis is placed on personal responsibility and supportive peer relations.

Recognition that enormous personality changes must take place to sustain sobriety should be facilitated, and negative attitudes and behaviour should be specifically addressed.

Family therapy and after-care follow-up for 1-2 years are important.

Relapse prevention strategies

These strategies provide the skills to anticipate and cope with high-risk situations and enable the person who 'slips' to overcome the 'violation' of abstinence commitment and reduce the negative effects of the drinking episode. Strategies include pharmacological agents such as disulfiram and behavioural techniques. Studies with naltrexone, an opiate antagonist that reduces craving for alcohol, show promising results. Drug therapy, however, plays only a minor role and should be in the context of psychological treatments.

Alcoholics Anonymous (AA)

This organisation has been described as 'an enormous potential resource' 24 - it is one of the most successful treatment approaches for alcoholism. Patients need not only the insights of therapy; isolated and demoralised, they also require a substitute dependency, new sources of hope and self-esteem, social support and a ritual reminder of the possibility of relapse. They need to experience forgiveness and reconciliation with the past. An eight-year prospective follow-up study showed that these needs are effectively met by AA and that stable abstinence is highly correlated with AA attendance.¹⁸

The Future

Budget constraints and therapeutic pessimism could further jeopardise treatment funding, but a significant association has been shown between increased treatment spending in the USA and decreased cirrhosis mortality, with linked huge cost savings.²⁵ Treatment is worthwhile. Virtually all studies show patients are better off after treatment than before. Our experience should be one of optimism, permitting us to tell the patient with conviction that recovery is possible.

The First step in psychotherapy is to help the patient gain insight in to addictive process .

References

1 Maynard A, Social costs of alcohol; is it helpful to measure the social costs of alcohol use? Catterick: Yorkshire Addictions Research. Training and Information. 1992,
Back To Section

2 Royal Colleges of Physicians, Psychiatrists and General Practitioners, Alcohol and the Heart in Perspective. London: RCP, 1995,
Back To Section

3 Paton A ABC of Alcohol London: BMJ Publishing Group 1994.
Back To First Reference Back to Second Reference

4 Findlay A, Alcohol use in Scotland Is there a growing health problem? Health Bull 1991; 49: 273-283,
Back To Section

5 Lord President's report on action against alcohol misuse. London: HMSO. 1991
[Back To Section](#)

6 Vaillant G, Natural History of Alcoholism. Cambridge. Massachusetts: Harvard University Press 1983,
[First Reference](#) [Second Reference](#)

7 Jaffe JH. Drug addiction and drug abuse, In: Goodman LS. Gilman AG (eds) The Pharmacological Basis of Therapeutics. 6th edn, New York: Macmillan. 1983,
[Back To Section](#)

8 Edwards G. Gross MM, Alcohol dependence: provisional description of a clinical syndrome, BMJ 1976; i: 1058-1061,
[Back To First Reference](#) [Back to Second Reference](#)

9 Schukitt M, Drug and Alcohol Abuse, New York: Plenum Publishing, 1995,
[Back to First Reference](#) [Back to Second Reference](#)

10 Chick J, Alcohol dependence an illness with a treatment? Addiction 1995;88: 1481-1492
[Back To First Reference](#)

11 Nutt DJ Balfour P Alcohol, opiates and the brain, Alcoholism (Medical Council on Alcoholism newsletter) 1996; 15(4): 3,
[Back To First Reference](#)

12 Morse RM ,Flavin DK The definition of alcoholism. Joint Committee of the National Council of the American Society of Addictive Medicine to study the definition and criteria for the diagnosis of alcoholism JAMA 1992;268:1012-1014
[Back to First Reference](#) [Back To Second Reference](#)

13 Chick J, Emergent treatment concepts, In Langenbucher JW. McCrady BS, Frankenstein W Nathan PE (eds), Annual Review of Addictions Research and Treatment. Vol 2, New York: Pergamon. 1992: 297-312.
[Back To Section](#)

14 Chick J, Brief interventions for alcohol misuse BMJ 1993; 307: 1374
[Back To Section](#)

15 Sobell MB. Sobell LC, Alcoholics treated by individualized behaviour therapy: one year treatment outcome, Behav Res Ther 1973; 11: 599-612,
[Back To Section](#)

16 Pendery ML, Maltzman IM. West LJ Controlled drinking by alcoholics? New findings and a re-evaluation of a major affirmative study. Science 1982; 217: 169-175.
[Back To Section](#)

17 Vaillant GE. Clark W, Cyrus C et al. Prospective study of alcoholism treatment - eight year follow-up, Am J Med 1983; 75: 455-563,
[Back To Section](#)

18 Helzer JE Robins LN Taylor JR et al The extent of long-term moderate drinking among alcoholics discharged from medical and psychiatric treatment facilities, N Engl Med 1985; 312: 1678-1682,

[Back To First Reference](#) [Back to Second Reference](#)

19 Walsh DC. Hingson RW Meringan DM et al, A randomised trial of treatment options for alcohol abuse, N Engl J Med 1991;325: 778-782,

[Back To Section](#)

20 Shaw GK. Waller S McDougal S MacGarvie J Dunn G, Alcoholism: a follow-up study of participants in an alcohol treatment programme Br J Psychiatry 1990-157: 190-196,

[Back To Section](#)

21 Harrison PA Hoffmann NG. Streed SG, Drug and alcohol addiction treatment outcome, In Miller NS (ed). Comprehensive Handbook of Alcohol-Drug Addiction, New York: Marcel Dekker. 1991.

[Back To Section](#)

22 Cook C, Minnesota Model, Br J Addict 1988; 83: 625-634.

[Back To Section](#)

23 Peters TJ, Re-education from alcohol misuse a physician's approach. Alcoholism (Medical Council on Alcoholism newsletter) 1993: 1:

[Back To Section](#)

24 Edwards G Treatment of Drinking Problems, London: Blackwell Scientific. 1987,

[Back To Section](#)

25 Smart RG. Mann RE. Lee s1., Does increased spending on alcoholism treatment lead to lower cirrhosis death rates? Alcohol Alcohol 1996-31 (5): 487-491,

[Back To Section](#)

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