Moderate drinking: an alternative treatment goal for early-stage problem drinking

MARION C. MCINTOSH,* MD
MARTHA SANCHEZ-CRAIG,† MD

Family physicians are in a particularly good position to identify problem drinking in its early stages through the recognition of various psychosocial and medical indicators. Thorough history-taking or the use of a specific questionnaire should provide confirmation. Patients so identified can then be offered treatment designed to help them moderate their drinking, if not to achieve abstinence. The treatment strategy described in this paper involves specifying a safe drinking pattern, instructing the patient in the use of aids to appropriate drinking and seeing the patient at 1- to 2-month intervals for follow-up assessment.

In a pilot study of this strategy 16 of 17 patients reduced their drinking substantially, and 8 were abstinent at the last follow-up visit. Only 1 of the 17 dropped out of treatment; the high rate of compliance may have been primarily due to the patient's need to see the family physician for other problems. Visits to the family physician for other medical problems provide an opportunity to motivate patients to continue monitoring their drinking.

Grâce à différents indices psychosociaux et médicaux, le médecin de famille est particulièrement bien placé pour dépister dans sa phase initiale l'ingestion excessive d'alcool. Une fois la chose confirmée, soit par un interrogatoire serré, soit au moyen d'un questionnaire prévu à cet effet, il est en mesure d'offrir à son malade les moyens de diminuer sa prise d'alcool, sinon de s'en abstenir tout à fait. On propose une "stratégie thérapeutique": prescription d'un programme de consommation inoffensive d'alcool, d'adjuvants à cette fin, et surveillance du sujet en visite de contrôle tous les mois ou tous les 2 mois.

Une analyse pilote de cette "stratégie" montre que de 17 sujets, 16 ont considérablement diminué leur prise d'alcool; 8 avaient même cessé complètement de boire lors de la dernière visite de contrôle. Un seul sujet a décroché. Souvent, c'est en raison d'autres ennuis de santé que le malade est resté en contact avec son médecin de famille, ce qui est peut-être un facteur important du succès de la "stratégie". La consultation pour d'autres ennuis de santé fournit au médecin de famille l'occasion d'encourager le malade à continuer à surveiller sa consommation d'alcool.

*Coordinator, drug and alcohol training, and assistant professor, Department of Family and Community Medicine, University of Toronto; staff, Family Practice Unit, Toronto General Hospital; head, Department of Family and Community Medicine, Clinical Institute, Addiction Research Foundation

†Assistant professor, Division of Community Health, Department of Behavioural Science, University of Toronto; clinical psychologist, Clinical Institute, Addiction Research Foundation

Reprint requests to: Dr. Marion C. McIntosh, Addiction Research Foundation, 33 Russell St., Toronto, Ont. M5S 2S1

Many people who present to alcoholism treatment facilities have serious medical and psychosocial problems.[1-3] The typical patient is 45 years old, has been drinking excessively for about 20 years and has been seen by many health care professionals, including physicians on many medical services in hospital.[4] The prognosis of these patients is rather poor.

Despite substantial evidence that those in whom an alcohol problem can be identified at an early stage have a more favourable prognosis,[5] to date few attempts have been made to intervene before serious symptoms of alcohol dependence develop. In our experience patients with early-stage problem drinking require little guidance to reduce their alcohol consumption to safe levels,[6] and they can easily be identified.[7] We believe that physicians in general practice can make a significant contribution to preventing alcohol problems. They are in an excellent position to identify patients who drink excessively, and they can intervene without special demands on their time or resources. This paper outlines an approach that could be used by these physicians and by other health care professionals.

Identification of early-stage problem drinking

Although many disorders have been associated with excessive drinking, it usually takes years before they become evident. Skinner and Holt[7] have identified a number of "earlier indicators" of alcohol abuse that can alert physicians to the possibility that their patient has a drinking problem (Table I). If during the routine history-taking or the initial physical examination several of these indicators are present, further assessment is recommended, and the patient should be questioned about his or her drinking practices.

Brief questionnaires such as the Michigan Alcoholism Screening Test (MAST)[8] and the CAGE questionnaire[9] can be very useful in assessing patients. They have good diagnostic accuracy when compared with laboratory tests,[10] and the pa-

tients generally respond well to them, especially to the CAGE questionnaire. The brief 10-item MAST provides an indication of the severity of the problem. It includes questions related to physical, social and legal consequences of drinking. The CAGE questionnaire consists of the following four questions: Have you ever felt the need to *C*UT down on your drinking? Have you felt *A*NNOYED by others asking about your drinking? Do you feel *G*UILTY about your drinking? Do you ever have an *E*YE-OPENER in the morning? A score of 5/10 on the MAST and 2/4 on the CAGE questionnaire indicates that a drinking problem is likely.

A simple way to elicit information on the patient's alcohol consumption is to inquire at the same time about other habits — for example, smoking, eating, drug use and physical activities. The physician should ask how much alcohol the patient consumes, rather than if he or she drinks. Since the consumption of alcohol is common, especially among men, the patient should not find this question surprising. In contrast to the person with chronic alcoholism, who tends to deny drinking in excess, the person with early-stage problem drinking usually answers the question readily. The minimum of information that the physician should have includes (a) the frequency with which the patient drinks per week or per month, (b) the typical number of drinks* consumed per drinking day and (c) the functions that the patient attributes to alcohol.

The functions that problem drinkers frequently attribute to their drinking heavily are as follows: to relieve negative feelings (e.g., depression, anxiety, boredom); to help them do something that they find difficult (e.g., express their anger, become more assertive or sociable; complete boring tasks); to enjoy themselves (i.e., they like the taste of alcohol or the effects of intoxication); to mitigate physical pain; and to help them sleep. Recognition of the functions thus attributed to alcohol is of great importance when attempting to develop a pattern of safe drinking.

*One drink is equal to 1.5 oz (43 mL) of spirits, 5 oz (142 mL) of wine, 12 oz (340 mL) of beer or 3 oz (85 mL) of fortified wine, such as sherry or vermouth. All of these are equivalent to 13.6 g of absolute ethanol.

Treatment strategy

The treatment strategy described in this paper was developed by the second author after extensive work with patients who had chronic alcoholism or early-stage problem drinking. This strategy represents an abbreviated version of the treatment procedures used to help patients with chronic alcoholism achieve total abstinence[11] and to help those with early-stage problem drinking achieve either abstinence or moderate use of alcohol.[6] The steps in the strategy are as follows:

Specify a safe drinking pattern

The following guidelines can be adopted for safe drinking:

- Do not drink daily.
- Limit your alcohol consumption on drinking days to four drinks.
- Never exceed 20 drinks per week. (In a previous study we found that patients who were most successful with nonproblem drinking did not have more than two drinks per week for 2 years.[12])

A safe drinking pattern must fit well into the patient's lifestyle and should not interfere with his or her health or important responsibilities. If the patient has regularly been drinking heavily, gradual reduction may be considered until a safe pattern is achieved.

Discuss aids to appropriate drinking

The patient can adopt the following measures to decrease his or her drinking and to avoid intoxication:

- Pacing drinking. Drinks should be measured, rather than just poured, diluted rather than consumed straight, sipped rather than

Table I—Checklist of possible earlier indicators of alcohol abuse*

Psychosocial factors
Heavy drinking (e.g., more than 6 drinks per day [80 g/d of ethanol])
Concerns about drinking by patient or family or both
Intellectual impairment, especially in abstracting and adaptive abilities
Light eating or skipping of meals when drinking
Quick drinking, increased tolerance to alcohol
Occurrence of accidents due to drinking
Tardiness or absence from work because of drinking (hangover)
Most friends are heavy drinkers, and most leisure activities involve drinking
Attempts to cut down on drinking have had limited success
Frequent use of alcohol to deal with stress, anxiety or depression
Frequent drinking during work day (e.g., at lunch break)
Heavy smoking
Laboratory findings
Elevated serum γ-glutamyl transpeptidase level (except in patients with nonalcoholic liver disease and those taking other drugs)
Macrocytosis without anemia (mean corpuscular volume is also sensitive to smoking habits)
Clinical symptoms and signs
Trauma
Scars unrelated to surgery
Hand tremor
Alcohol fetor by day
Dyspepsia
Morning nausea and vomiting
Recurrent diarrhea
Pancreatitis
Hepatomegaly
Polyuria
Impotence
Palpitations
Hypertension
Insomnia, nightmares

***Adapted, with permission, from reference 7.**

gulped, alternated with nonalcoholic beverages and spaced out. The patient should also avoid drinking on an empty stomach.

- Keeping records. A daily record of the number of drinks consumed will allow the patient to make an accurate assessment of his or her progress. Keeping notes of successful ways of dealing with temptations to drink too much, and with pressures from others to drink, is a useful way of recognizing approaches that really work.
- Preparing to avoid heavy drinking. This involves thinking of ways to approach situations in which there will be a risk of excessive drinking. For example, the patient must learn how to refuse drinks without feeling antisocial and how to counteract rationalizations to go over his or her limit.
- Developing activities that are incompatible with heavy drinking and will fill the time that used to be spent in heavy drinking. This will help the patient achieve a safe drinking pattern.

Offer advice on problems of daily living

Since problems of daily living (e.g., marital or family conflicts, boredom, job dissatisfaction) tend to interfere with plans to reduce or to stop drinking, the patient is advised to find adequate solutions to these problems as quickly as possible, with professional help if necessary. The patient must keep in mind that alcohol should not be used to cope with problems.

This strategy can usually be implemented in two sessions of approximately 30 minutes each, conducted 2 weeks apart. In the first session the patient is given assistance in selecting a safe drinking pattern (or an initial goal for reduction of drinking) and is instructed in the aids to appropriate drinking. The patient is also asked to keep daily records and to list the leisure activities with which he or she will fill the time previously spent in heavy drinking. The physician emphasizes the importance of bringing the records to the next visit.

The second session is mainly devoted to ensuring that the patient has a clear understanding of the procedures he or she should follow in attempting to achieve a safe drinking pattern. Adjustments to the drinking goal can be made at this time. If the patient is having difficulty in finding activities incompatible with heavy drinking or in solving problems of daily living, referral for appropriate professional help is discussed. At the end of this session the physician stresses the importance of keeping accurate daily records of the number of drinks consumed. The patient is told that heavy drinkers who succeed in decreasing their drinking tend to persist in keeping accurate records until a safe drinking pattern is well established.

The patient should be seen on a long-term basis at 1- or 2-month intervals. He or she should be encouraged to maintain daily records of alcohol consumption for at least 6 months and to bring these records to every visit. This information is extremely valuable for monitoring the patient's progress and for providing motivational support. In other words, if reductions in drinking can be associated by the physician with improvements in health (or in other areas of living), the patient's motivation to keep his or her drinking under control will probably be maintained.

Pilot study

Before performing a controlled trial in a family practice unit, plans for which are under way, we conducted the following pilot study of this treatment strategy to determine whether it would be practical in a family practice.

Method

In November 1981 the first author began to apply the treatment strategy and to gather data on the patients so treated at an alcohol treatment centre. This strategy was later applied at a teaching hospital. The patients had been identified as problem drinkers by their drinking history or by MAST or CAGE as-

sessment. Most were seen as part of the author's regular family practice at a downtown teaching hospital, but some had been referred from colleagues. Of the 17 patients selected for treatment 5 were alcohol-dependent and were offered this form of treatment because they had rejected traditional abstinence-oriented programs; 3 of them were the first patients to whom the first author had applied the strategy, at a family practice clinic at the Clinical Institute, and the other two had refused to become involved with an alcoholism treatment facility.

The treatment strategy and its goals were explained to the patients during their first visit. They were asked to return within 1 week for full history-taking, a physical examination and basic laboratory tests. The level of alcohol in the urine was measured by an alcohol dipstick at every visit to confirm the patients' statements on their current drinking. The patients were informed of any abnormal physical and laboratory findings (e.g., enlarged liver, elevated blood pressure, high serum levels of liver enzymes or uric acid, and elevated mean corpuscular volume of red blood cells).

Observations

All the patients who were offered the treatment returned for at least one visit after the initial contact. Only one patient dropped out of the study. Of the 17, at the time of writing 14 had been followed for a minimum of 6 months, 9 of them for at least 1 year and the other 5 for 2 years.

Of the 17 patients 9 were men and 8 women. Their ages ranged from 22 to 82 years. Nine were employed, four were unemployed, two were housewives and two were retired. Nine were living alone; the other eight were living with a spouse, friend or relative. The majority (nine) had at least a high school education.

The most common physical abnormality among the patients was elevated blood pressure. Other medical problems included melena, fainting spells, insomnia and blackouts.

Before treatment began, the patients' weekly alcohol consumption ranged from 12 to 130 drinks; by the last follow-up visit nearly half were abstinent, and none were consuming more than 35 drinks per week (Table II).

Table II—Drinking patterns of 17 problem drinkers before treatment and after at least 6 months of follow-up visits

	No. of patients	
Drinks/wk	Initial visit	Last visit
0	0	8
1–14	1	4
15–35	3	5
36–63	7	0
64–130	6	0

Discussion

Until recently there have been only two approaches to the management of alcohol abuse — primary prevention and treatment of the fully alcohol-dependent patient. In this paper we have suggested another approach — identifying alcohol abuse before full alcohol dependence develops, then helping the patient keep his or her drinking under control through brief intervention. The early signs of problem drinking can be recognized by taking a thorough history of the patient's use of alcohol. The brief intervention we have described is quite feasible for a family physician to use.

One problem with traditional treatment of alcohol abuse is the high dropout rate. However, dropout may not be as likely when the therapist is the patient's family physician, since the patient will be consulting the physician for other problems at various times. Our experience suggests that patients with hypertension and other illnesses requiring follow-up persist longer in attempting to control their drinking. Feedback on their medical status seems to be very important, as it often persuades them to resume monitoring their alcohol use if they have stopped doing so. However, further data are required to substantiate these observations.

References

1. ASHLEY MJ, OLIN JS, LE RICHE WH et al: The physical disease characteristics of inpatient alcoholics. *J Stud Alcohol* 1981; 42: 1–14

2. LELBACH WH: Organic pathology related to volume and quantity of alcohol use. In GIBBONS RJ, ISRAEL Y, KALANT H et al (eds): *Research Advances in Alcohol and Drug Problems*, vol 1, Wiley, New York, 1974: 118–140

3. MÄKELÄ K: Level of consumption and social consequences of drinking. In ISRAEL Y, GLASER FB, KALANT H (eds): *Research Advances in Alcohol and Drug Problems*, vol 4, Plenum, New York, 1978: 303–348

4. MCINTOSH ID: Alcohol-related disabilities in general hospital patients: a critical assessment of the evidence. *Int J Addict* 1982; 17: 609–639

5. OGBORNE AC: Patient characteristics as predictors of treatment outcomes for alcohol and drug abusers. In ISRAEL Y, GLASER FB, KALANT H et al (eds): *Research Advances in Alcohol and Drug Problems*, vol 4, Plenum, New York, 1978: 181–185

6. SANCHEZ-CRAIG M, ANNIS HM, BORNET AR et al: Random assignment to abstinence and controlled drinking: evaluation of a cognitive–behavioral program for problem drinkers. *J Consult Clin Psychol* 1984; 52: 390–403

7. SKINNER HA, HOLT S: Alcohol abuse strategy for early detection and brief intervention. Presented at AMERSA meeting, Berkeley, Calif, Nov 15–16, 1982

8. POKORNY AD, MILLER BA, KAPLAN HB: The brief MAST: a shortened version of the Michigan Alcoholic Screening Test. *Am J Psychiatry* 1972; 129: 342–345

9. MAYFIELD D, MCLEOD G, HALL P: The CAGE questionnaire: validation of a new alcoholism screening instrument. *Am J Psychiatry* 1974; 131: 1121–1123

10. BERNADT MW, MAINFORD J, TAYLOR C et al: Comparison of questionnaires and laboratory tests in the detection of excessive drinking and alcoholism. *Lancet* 1982; 1: 325–328

11. SANCHEZ-CRAIG M, WALKER K: Teaching coping skills to chronic alcoholics in a co-educational halfway house. *Br J Addict* 1982; 77: 35–50

12. SANCHEZ-CRAIG M, WILKINSON DA, WALKER K: Theory and methods for secondary prevention of alcohol problems: a cognitively based approach. In COX WM (ed): *Treatment and Prevention of Alcohol Problems. A Resource Manual*, Acad Pr, New York (in press)