ABC of Alcohol

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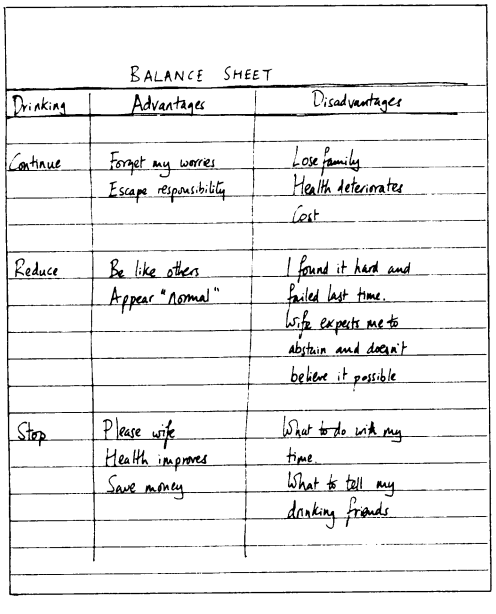
HELPING THE PROBLEM DRINKER

Other articles in this series have shown that alcohol is a health issue and that patients' drinking habits are, like smoking, a matter for clinical inquiry. The doctor has a responsibility to advise his patients about sensible drinking and to recognise alcohol-related problems at an early stage.

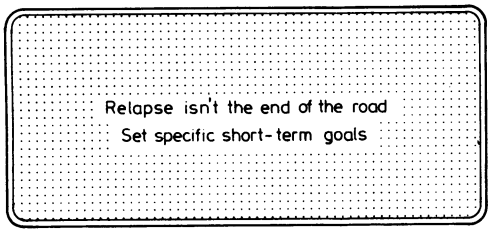
Many people are sensitive about their drinking, and the offer of help will be more readily accepted if it is given in a spirit of concern for health and the family's wellbeing. It is usually misplaced to be judgemental, and dire warnings are rarely heeded unless they occur in a setting of mutual trust and respect. Once these preconditions exist simple advice from the general practitioner about changing habits is often surprisingly effective.

How to help and how to motivate



BALANCE SHEET

Drinking	Advantages	Disadvantages
Continue	Forget my worries Escape responsibility	Lose family Health deteriorates Cost
Reduce	Be like others Appear "normal"	I found it hard and failed last time. Wife expects me to abstain and doesn't believe it possible
Stop	Please wife Health improves Save money	What to do with my time What to tell my drinking friends



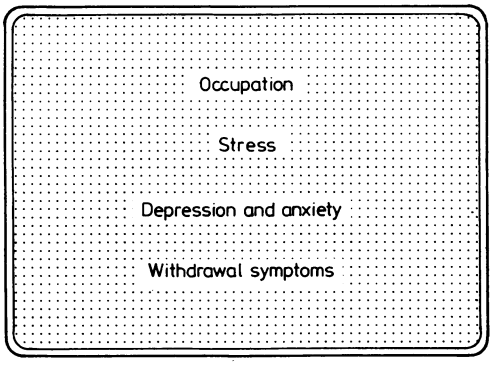
Most doctors are pessimistic about being able to help alcoholics, yet there is good evidence that as many as two-thirds respond well to treatment. The family doctor is ideally placed to recognise the problem early and intervene.

Motivation is a rather suspect concept. We often blame the patient for lack of motivation when relapse occurs, but, in common with many medical conditions, the treatment of alcohol problems is characterised by relapses and remissions. Relapse is not necessarily the end of the therapeutic road, and the strength of motivation is certainly not constant. A reluctant patient brought by a desperate spouse or coming to avoid dismissal from work can often be converted into taking a personal responsibility for stopping or reducing his or her drinking.

The patient has acquired a drinking habit which is damaging his personality, his family and social life, or his health. Our habits are often hard to change, and the patient will be ambivalent about changing his drinking pattern. This ambivalence can often be addressed directly by asking the patient to draw up a balance sheet of the good and bad consequences of his continued drinking.

Armed with such evidence the patient should set realistic goals for changing his or her lifestyle. It is best to aim for specific short-term goals at first so that the patient gets a sense of achievement by attaining, for instance, three weeks' abstinence or even a party negotiated without disgrace and then reporting progress. This is often preferrable to global but ill-considered promises such as, "I shall never touch another drop." Alcoholics Anonymous embodies the good sense of this approach in its recommendation that the alcoholic should take "only one day at a time."

Changing the lifestyle: impediments



For many problem drinkers drinking has become their predominant interest; to achieve the desired goal they will in time have to make major changes in their way of life. The patient will need help to look at impediments to change and alternatives to drinking.

The impediments will either be evident from the initial balance sheet or become clearer as the drinker tries to change his habits. Impediments may be, for example, a job where drink is readily available, family stress which the drinker cannot cope with without alcohol, an established neurosis or depression which has been masked by drinking, or the occurrence of withdrawal symptoms when he tries to stop drinking. The patient should look out for situations and feelings which "trigger off" drinking and work out new ways of coping with them.

Changing the lifestyle: alternatives to drinking

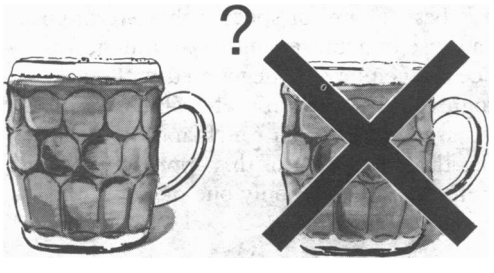
At its simplest patients can be asked to think of activities they enjoy which do not involve drinking. The answer to this question may initially be "none." Alternatives often become clearer if specific attention is paid to past triggers for drinking—for example, the drink at the end of the day may be avoided by going home earlier, the pre-match drink by meeting at the ground itself, and so on. Anxiety as a trigger to drinking may be relieved by appropriate relaxation training. Sometimes more elaborate help focused, for example, on tensions in the family may be necessary. The clinician should not discount the more obvious seemingly mechanical and naive solutions, which often prove surprisingly effective.

Involve the spouse

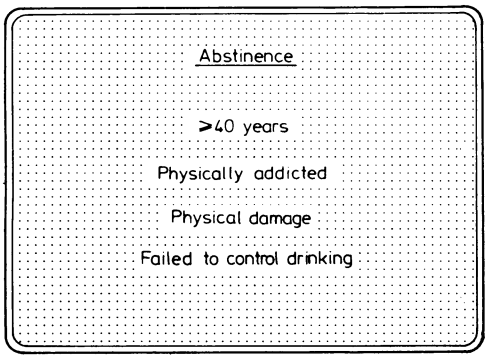
The spouse is often the prime mover in getting help for the patient. He or she should be actively involved in consultations, partly as an additional source of evidence about the true state of affairs and as an aid to helping the family find a new way of life that does not involve drinking.

The family will have made certain protective adaptations to cope with its drinking members and will need to adjust to the new abstinent personality in its midst. Trust takes time to be re-established and the family will often need support during periods of relapse in which the spouse may feel that all is irretrievably lost. The spouse of an alcoholic often feels confused, bitter, and devalued and will welcome the chance of being understood and participating in the process of recovery.

To drink or not to drink



The goal of intervention will depend on the extent of the patient's drinking problem. If the drinking is excessive but hitherto harm-free, the doctor should advise about safe limits for drinking, such as "two or three pints a day two or three times a week," keeping in mind the evidence that those who regularly drink more than five pints of beer or its equivalent daily are seriously endangering their health.



Some drinkers with established problems will return to moderate harm-free drinking, but it is difficult to predict who will succeed where others fail. Present evidence suggests that abstinence remains the preferred goal for those who are over 40, are seriously physically addicted, have evidence of physical damage, or have tried controlled drinking treatment without success. For younger people whose problem drinking has been detected at an early stage and who are not seriously addicted or damaged modified drinking may be a more acceptable and feasible goal.

Most specialists have probably become less insistent on abstinence as the goal and are willing to consider modified drinking. This needs to be carefully planned and discussed and is best preceded by a period of abstinence until evidence of physical harm has disappeared.

Review

Week commencing 25 May 1981

Record exactly what you have drunk on each day last week

	Beers (pints)	Spirits (glasses)	Others including wine (glasses)	Place where consumed
Monday	3			Pub at lunchtime
Tuesday	4	2 whiskies		Pub/friends/evening
Wednesday				
Thursday	8			Evening/friends/payday
Friday	4 (lunchtime) 5 (evening)	2 whiskies		Row with wife
Saturday	2 (lunchtime)		1 bottle wine (dinner)	Home with wife
Sunday	2 (lunchtime)	2 whiskies (evening)		Pub with wife and friends

Whatever the agreed goals, it is essential that the doctor regularly reviews the patient's progress. The most important task at the first interview is to gain the patient's interest in tackling his or her drinking problem and to ensure that he or she returns for the next appointment. At this time the short-term achievements and problems can be reviewed and further goals agreed.

Supportive laboratory tests (γ-glutamyl transpeptidase, mean corpuscular volume, and blood alcohol) are useful objective means of monitoring progress, and the results and their implications should be discussed with the patient. A diary in which the patient makes a note of any drinks consumed, the time, their quantity, and the occasion is a useful aid to self-audit.

Progress should be reviewed regularly over a year. The first six months of progress often give a good impression of longer term prognosis.

Relapse

What happened – a behavioural analysis

When ?

Where ?

Who was there ?

How much did I drink ?

How often did I drink ?

Most patients will drink again whatever the original goal of treatment but this need not be a catastrophic relapse involving the loss of all that has been achieved. It is more profitably viewed as an opportunity for the patient to learn more about the nature of himself and the problem. Dealing with and learning from relapses is part of recovery. It needs to be taken seriously by the doctor and patient, and the questions shown opposite need to be honestly asked and answered. Once the anatomy of a relapse is laid bare in this way the patient can recognise strategies for preventing a recurrence.

A closer study of relapses should help patient and doctor to identify triggers to drinking, which may be listed. The family often feels particularly threatened and confused by a relapse and will need extra support at this time.

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