How to Guide the Alcohol-Dependent Patient Toward Recovery

Conventional wisdom has it that heavy drinkers aren't interested in getting help. But in fact, many are—and there are simple, focused steps you can follow to keep them motivated.

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Mr. J, a 44-year-old engineer, presents to an urgent care clinic accompanied by his wife and reports a four-month history of fatigue, trouble sleeping, stomach pain, and marital problems. He has no other significant past medical or surgical history. He says his father had problems with alcohol and died of a stroke; his mother, a smoker for many years, has emphysema.

Mr. J's vital signs are normal except for a heart rate of 95. He's mildly overweight. His physical exam is notable for epigastric tenderness and a slightly enlarged liver. There is a faint smell of alcohol on his breath. His wife slipped a note to the nurse earlier saying she's quite concerned about her husband's drinking, but he doesn't think it is a problem. She doesn't want her husband to know about the note.

How would you assess and manage Mr. J's case?

INACCURATE PERCEPTION

There is a widespread but inaccurate perception that heavy drinkers aren't interested in getting help. Couple this less-than-optimistic perception with a lack of training in managing these patients and a bad experience or two with an intoxicated patient and it becomes understandable why health professionals might be dubious. But according to the recently updated National Institutes of Health (NIH) guide *Helping Patients Who Drink Too Much*, physicians in urgent care settings are "in a prime position to make a difference" by in-

corporating alcohol screening and intervention into their practice.

Recent studies show that heavy drinking is not often recognized in the primary care setting. In fact, one study suggests that only about 10% of patients are appropriately assessed and referred for treatment. However, interestingly, recent research also suggests that when primary care patients are screened for alcohol dependence, they are often already motivated to make some kind of change. Clinical trials have shown that even brief interventions can make a significant difference in the behavior of heavy drinkers. Some will readily accept referral for treatment. Those who don't still benefit from follow-up visits that focus on changing the drinking behavior.

There is a step-by-step process that can allow you to assess whether a patient like Mr. J is ready to deal with his drinking problem. The NIH guide offers two options for screening: One is a single question and the other is the Alcohol Use Disorders Identification Test (AUDIT), a written self-report. Some practitioners prefer to have the patient complete the AUDIT before the physical examination.

The first option, the question, is a simple screening tool drawn from epidemiologic research that found men who drink five or more standard drinks a day (or 15 or more per week) and women who drink four or more drinks a day are at increased risk for alcohol-related problems. A standard drink is defined as 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80 proof spirits. The screening question, then, for men, is *How many times in the past year have you had five or more drinks in a day?* Or, for women, … *four or more drinks in a day?* If the response indicates one or more heavy drinking days, the clinician can move on to offer the AUDIT questionnaire. A score of more than 4 for women and more than 8 for men indicates a positive screening.

Another option, and one that for some may be easier to blend into questions about general health, is the CAGE questionnaire: *Have you ever felt you ought to **C**ut down on your drinking? Have people **A**nnoyed you by criticizing your drinking? Have you ever felt bad or **G**uilty about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?* Two or more positive answers are correlated with alcohol dependence in about 90% of cases.

FIVE STAGES OF CHANGE

Prochaska and DiClemente have written eloquently about how our concept of personal motivation has changed in addiction treatment. Their model has been called the "Stages of Change." The five stages are: *precontemplation, contemplation, preparation, action,* and *maintenance.*

This model for working with patients struggling with addiction suggests that just because patients don't change their behavior doesn't necessarily mean that they aren't motivated. They *are* motivated—to continue a behavior they truly believe they can't enjoy life without.

Clinicians, however, can help by encouraging and educating patients at each of the various stages of change. In the first stage, *precontemplation,* patients show increased awareness of the need to change. The clinician can help at this stage by teaching the patient about the role of alcohol in causing or maintaining health problems such as high blood pressure, gastrointestinal problems, insomnia, and insulin resistance. Laboratory tests that objectively demonstrates harm caused by alcohol could be helpful at this point (see box on page 34).

After the patient is aware of the need to change, he moves to *contemplation*. Here, he's sorting out whether changing is in his best interest. During this stage, the clinician can help by reinforcing reasons for change and discussing the risks of delaying or avoiding change.

When the patient makes a commitment to change his behavior, the clinician can work with him to develop an effective plan (*preparation).* At the *action* stage, the clinician can help implement the plan or change it as needed. Actual behavior changes should be seen at this stage: attending AA meetings, avoiding the people and places associated with alcohol, exercise, etc. A common statement to a patient in addiction treatment settings is, "I hear your words. Please show me the changes in what you are doing, too."

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>>FAST TRACK<<

Even brief interventions can make a significant difference in the behavior of heavy drinkers.

Laboratory Tests for Alcohol Dependence

There are currently four lab tests for detecting excessive alcohol consumption.

Gamma-glutamyl transferase (GGT) is a liver enzyme that increases after long-term, heavy drinking (four to eight weeks of drinking four or more drinks a day). It is also helpful for monitoring abstinence since it usually takes four to five weeks of abstinence for GGT levels to return to normal. Liver diseases that are not alcohol-related and obesity can cause false positive results.

Carbohydrate-deficient transferrin (CDT) is a blood protein that also increases with heavy alcohol consumption. An elevation in CDT can be seen after only one to two weeks of binge drinking. This marker has a lower sensitivity in women and adolescents.

Mean corpuscular volume is a well-known index of red blood cell size, which increases after overuse of alcohol over four to eight weeks. However, it is a poor indicator of recovery.

Ethyl glucuronide (EG) is a direct metabolite of alcohol detectable in the urine, blood, and hair for several days. It is used to test for recent exposure to alcohol. Its usefulness extends beyond the limits of blood levels or Breathalyzers. However, it is difficult to use EG to distinguish between drinking and incidental alcohol exposure (for example, from mouthwash or cough syrup). More research is needed before EG can be useful in legal settings.

Maintenance is a long-term stage in which the patient incorporates the desired changes into his life. If the patient relapses (which is unfortunately more likely than not), the clinician can use the stages of change to help the patient get back on the path of recovery. Clinician-led relapse-prevention strategies are often helpful during this stage. Relapse should be looked upon as an opportunity to learn rather than a reason to give up.

>>FAST TRACK<<
Antabuse should be reserved for the highly motivated person.

PROS AND CONS OF ADJUNCTIVE DRUGS

Disulfiram (Antabuse) was the first drug approved for the treatment of alcohol problems. It causes an aversive reaction to alcohol when acetaldehyde, a breakdown product of alcohol, accumulates. The so-called "Antabuse reaction"—flushing, nausea, vomiting, throbbing headache, sweating, and hyperventilation—is generally in proportion to the amount of alcohol cursumed. Antabuse can cause hepatotoxicity, depression, and psychotic episodes; a few deaths have also been associated with it. Liver-profile monitoring is recommended.

Antabuse should be reserved for the highly motivated person. The question that needs to be addressed, however, is: If the patient is so highly motivated, why should disulfiram be necessary? In my experience, it is most useful in preventing relapse. One patient I'm aware of used it only when she traveled to conferences, since this had been a time of high risk of relapse for her.

Naltrexone (ReVIA) is an opiate antagonist approved as an adjunctive therapy to psychotherapy. Naltrexone blocks primarily the mu opiate receptors, and it is thought that this inhibits the euphoric effects from the release of endogenous opioids caused by alcohol. Theoretically, this reduces the positive reinforcing effects of alcohol. Naltrexone's most common side effect is nausea; dysphoria and elevated liver function tests have also been reported. Liver-profile monitoring is recommended.

An extended-release (30 days) injectable form of naltrexone has recently been released, with the same side-effect profile as the oral form. The injectable form has obvious advantages in terms of compliance. However, it is very expensive–about $600 per injection. Oral dosage varies from 50 to 100 mg/day.

Acamprosate (Campral) helps balance the edgy, anxious, agitated feelings caused by the rise in glutamate levels following the sudden discontinuation of alcohol after a period of heavy drinking. Glutamate is the major excitatory neurotransmitter in the nervous system, while acamprosate is similar to GABA, the major inhibitory neurotransmitter in the nervous system. The drug is supplied in a 333-mg tablet; the recommended dosage is 666 mg three times daily.

Other medications are also being considered for possible use in treating alcohol dependence, including ondansetron, topiramate, valproate, and carbamazepine, as well as the selective serotonin reuptake inhibitors fluoxetine and sertraline.

Starting the Conversation About Change

Here's an example of how one might use motivational enhancement therapy to engage with Mr. J, the patient who has presented to an urgent care clinic with symptoms of alcohol dependence. Some of the dialogue below incorporates the "Stages of Change" model for treating addictive behavior mentioned in the article.

The physician has already asked about the various presenting medical problems in a regular fashion. This establishes the clinician as concerned and medically focused. Asking about alcohol use can then be integrated into the same medical history.

Doctor: "Is there a history of any medical problems in your family?"

Mr. J: "My father died of a stroke and my mother has emphysema."

"Did your father smoke cigarettes too?"

"Yeah, he smoked. Drank too, just like everybody else."

"Were you ever concerned about his drinking?"

"Oh, yeah. He was a mean drunk."

"Are you concerned about your drinking?"

"I am when it gets me in trouble."

"Can you tell me about when it gets you into trouble?"

"Well, there was the DUI last year."

"Did that change how you think about your drinking?"

"Well, it got me in jail and it cost me a lot of money. I quit for a while."

"Then what?"

"I figured I couldn't be an alcoholic if I could stop drinking for two months. So I started having a drink now and then."

"Can you describe your drinking habits over the last few months?"

"It's mostly on the weekends. I work hard all week and I feel like I deserve a break on the weekend."

"What do you drink?"

"Beer mostly. It's nothing for me to put away a couple of six packs or more over the weekend. I'll usually have two or three beers at night during the week, but not every night. I can take it or leave it during the week."

"Mr. J, I think how you use alcohol could be contributing to the problems that brought you here today. **[Precontemplation stage]** I don't think your drinking is normal. If it's O.K. with you, I'd like you to take a quick test that will help sort out whether alcohol is a problem or not."

At this point the physician could administer the AUDIT questionnaire (available online from the National Institute on Alcohol Abuse and Alcoholism at www.niaaa.nih.gov/guide). Clearly, Mr. J would score above 8 on this test: He has more than five to six drinks a day two to three times a week; his wife has been concerned about his drinking within the last year; and now a doctor has suggested he cut down.

Then the conversation might continue like this:

"Mr. J, your score on this test suggests that alcohol is a problem for you. I wonder, have you been thinking about doing anything about your drinking?"

"Yeah, I've been thinking about stopping again. I got in the car after a few beers the other night. I could have been in real trouble if I'd been stopped coming home." **[Contemplation stage]**

"When was your last drink?"

"Yesterday."

continued

Starting the Conversation About Change *continued*

"Have you ever had any withdrawal symptoms? Tremors, sweating, heart beating fast, insomnia? Any symptoms like that?"

"Nothing real serious. Just felt nervous for a few days and couldn't sleep. Wanted a beer real bad."

"O.K., I can help with that nervousness and that urge to drink. That's a short-term problem. I'd like to give you some samples of a medicine that can help with this, but the harder problem is to help you find a way to avoid alcohol completely. Will you come back in two weeks to see how you're doing with the medicine and talk more about a longer-term plan?"

"I'm not big on taking pills. But if it will make me feel better and it's not addicting, I'll give it a try for a little while." **[Preparation stage]**

"I appreciate your willingness to work with me. Just to be clear, I'm asking you to not drink any alcohol because, number one, the test shows that alcohol is a problem for you and, number two, I think the physical problems that brought you here tonight were caused by alcohol."

"Oh, I can stop drinking anytime."

"Great, show me what you can do. See you in two weeks. Oh, I almost forgot, I would like to get a couple of blood tests to see if your liver and blood cells are all right. We'll go over the test results in two weeks when you return."

When, hopefully, Mr. J returns in two weeks, further efforts would be made to move him along in recovery. The first step would be for the physician to re-establish that the two of them are trying to evaluate his drinking and devise a plan to make him healthier. It is critical for the physician to avoid taking an adversarial position. It would be easy to simply tell him that he needs to stop drinking, but the physician must take a higher road by maintaining a therapeutic stance with the patient. One way to do this is by focusing on what the patient has accomplished (he came for help, he didn't drink for a while, he took his medication, he came back to his follow-up appointment), and by focusing on the goal of helping him get as well as possible.

The conversation might go something like this:

"Thank you for coming back to see me. How has it gone with sobriety?"

"Piece of cake, doc."

"So you didn't drink any alcohol?"

continued

PSYCHOTHERAPEUTIC OPTIONS

While medications can be quite helpful in treating alcohol problems, psychotherapy continues to play a major role in helping these patients. There are three major approaches: cognitive behavioral therapy, motivational enhancement therapy and 12-step facilitation therapy.

>>FAST TRACK<<
Cognitive behavioral therapy is particularly helpful in examining a relapse.

Cognitive behavioral therapy. This technique focuses on connecting how a person thinks with how a person behaves. The clinician helps the patient examine the process of drinking from beginning to end. This is particularly helpful in examining a relapse. A common expression related to this is: "Think through the drink." For example, as opposed to telling the person that he can't drink, you might ask the patient to describe the entire process of returning to drinking with questions such as the following:

- Where would you go to drink?
- What would you drink?
- With whom would you drink?
- What would happen after you finished drinking?
- How would your family feel about your drinking?
- What has happened when you drank before?
- What leads you to think that this time will be different?
- Have you ever told yourself that before?

This could become an opportunity to teach the

"Not a drop. And I'm staying away from the guys I drink with." **[Action stage]**

"Wonderful. How are you feeling?"

"Better. I'm sleeping better."

" How about your energy and the stomach problems you had?"

"I'm not as tired. My stomach feels better."

"Good, I'm glad to hear that. I have your test results here. They're all normal except for a liver test called the GGT, which is slightly high. There are three liver enzymes that we test. This one, the GGT, goes up before the other two when the liver has been damaged by alcohol. The other abnormal test is called the mean corpuscular volume, and it tells me that your red blood cells are swollen. Too much alcohol in a person's system over time is the most common cause of this."

"I work in a factory where there are a lot of chemicals. Could that be causing it?"

"It's possible. There are some other tests we could do to check on that, but I'm pretty certain that alcohol is the culprit."

"I'd like to get those other tests done."

"O.K., I can do that. But the important thing is that we keep working on a plan to keep you sober."

"I'm done with drinking."

"I believe you when you say that. I just want to do everything we can to make sure this is the last time you ever have to go through this. It gets harder and harder on your body."

"I'll be fine. Just help me get my liver healthy again."

"It takes some time away from alcohol for the liver and blood cells to get back to normal. We can check them again in about a month. While we're waiting for that to happen, I would like you to either have a few sessions with this counselor who knows a lot about helping people stop drinking permanently or go to two AA meetings a week until I see you again."

"I don't care for counselors. I went to AA when I had the DUI. They just tell stories. But I'll go to a few meetings if you want me to."

"Great! I think you'll get more out of AA now that you've taken the first step on your own. We'll recheck your liver tests then as well as your red blood cell test when you get back in a month."

problem drinker about denial. (Even after 20 years of working in this field, the power of denial continues to surprise me.) The clinician is looking at the problem drinker's plan to drink again and sees nothing but disaster. The problem drinker looks at the same plan and sees an opportunity to try to drink normally. He can only see the romance and allure of the drink, while the clinician can only see DUIs, accidents, and liver disease.

The cognitive behavioral therapist might ask the problem drinker to do a homework exercise, such as writing out the consequences of the last 10 times he drank alcohol. The clinician and patient might problem-solve together after developing an appreciation of how powerful denial can be. They might, for example, develop a list of steps to take if the urge to drink presents itself. That list might include calling the therapist, calling a person in recovery from alcohol, calling a hotline, vigorous exercise, writing for 30 minutes, or telling the people around him about the issue (that is, avoiding secrecy).

Motivational enhancement therapy. This intervention is quite straightforward. Specific goals (in this case, to change drinking behavior) are sought through the use of motivational psychology. It is often limited to four sessions.

This approach incorporates and depends on the patient's responsibility. The foundation is Miller and Rollnick's stages of change: *precontemplation, contemplation, preparation, action, maintenance*, and *relapse.* Motivational interviewing is the primary technique, using five guidelines: express empathy, support the patient's

self-advocacy, avoid arguing, roll with resistance, and develop discrepancy.

The interview with Mr. J (see sidebar beginning on page 35) is an example of motivational enhancement therapy. The goal is to create a therapeutic relationship in which the clinician and the problem drinker work collaboratively toward the goal of getting the patient as healthy as possible. This approach allows the clinician to work with individuals who may have little or no motivation for change. Essentially accepting that the patient is where he is, the clinician tries to find out where the patient is uncomfortable or ambivalent about alcohol and then move him from one stage of change to the next. The old idea that a person has to hit a terrible or tragic bottom is giving way to a new concept of change referred to as helping the person "raise the bottom."

Twelve-step facilitation therapy. Alcoholics Anonymous (AA), of course, is the largest and best-known exemplar of this therapeutic option. One of the fundamental principles of AA is that alcohol dependence is a disease, countering the popular belief that problems with alcohol are due to moral issues or a lack of willpower. The "Big Book of AA," written by its founders, Bill W. and Dr. Bob, establishes that the requirement for being a part of AA is simply "a desire to stop drinking." Being abstinent is not a requirement. It also emphasizes the importance of personal honesty as key to the process of recovery.

As of 2005, there were more than 2 million members of AA in more than 105,000 AA groups all over the world. Contrary to some impressions, AA is not a religious organization. Belief in a "higher power" is one of its core principles—but each member's definition of that higher power can be almost anything so long as the person has a sense that it is greater than him. Those who have had negative religious experiences often use AA itself or nature for their higher power.

>>FAST TRACK<<
A new concept of change is referred to as helping the person "raise the bottom."

Going to AA meetings helps the person immediately connect with a group of people who have learned to enjoy life without alcohol. Members who have had a long period of solid recovery serve as sponsors or mentors to those just entering the program. It's worthwhile for clinicians to attend a few AA meetings to gain a sense of how the meetings proceed.

KEEPING THE PATIENT ON THE PATH

Urgent care clinics and emergency departments are settings in which the effects of alcohol abuse are often seen for the first time. Heavy drinking is, of course, a factor in a significant percentage of motor vehicle accidents, incidents of domestic violence, suicides, and trauma cases. But heavy drinkers also are at greater risk than moderate drinkers or nondrinkers for various medical problems that can bring them in for help, such as hypertension, gastrointestinal bleeding, sleep disorders, and hemorrhagic stroke.

Continued follow-up may not be an option in the urgent care setting, in which case it may be necessary to refer to the patient to his primary care physician. But no matter the setting, the concept of accepting the patient where he is and then trying to gently move him to the next stage of recovery can work—and work well. □

SUGGESTED READING

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