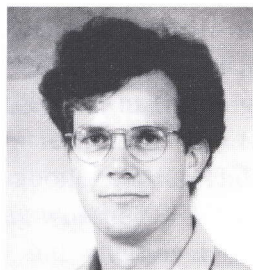


# Managing Alcoholic Patients

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## Curriculum Vitae

Rolf was born in 1958 in Zwollerkerspel, the Netherlands, and graduated in November 1985 at the Rijksuniversiteit of Groningen (NL). After an elective period in Eastern Africa, he did a preparatory housemanship in s'Hertogenbosch (NL) and then started to work in the Donald Fraser Hospital in Venda, Republic of South Africa in 1987 as a medical officer. He developed a special interest in psychiatry and community health, and held the post of deputy superintendent till repatriation in March 1994. He is busy trying to finalise the M Fam Med through Medunsa, and is presently doing locums while pondering his future career. He is married to Loes Kolleman who is also a doctor.

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## Summary

*One patient with an alcoholic problem started the author off on some research on alcoholism, which he describes here. He advocates flexibility in the therapy but gives step-by-step guidelines for the GP who could be confronted with a similar problem: any suspicion should be followed up and a diagnosis should be made. Motivation for change seems to be the most important role for the GP, but some knowledge about therapy and self-control procedures could be very helpful when supporting the patient through his difficult periods of change.*

## Patient Presentation

*Peter came together with his brother. He was about 45 years old, healthy-looking and apparently upset. According to his brother he had been a bit confused for several days, hearing voices, talking alone and pacing restlessly up and down, especially during the night. It started after excessive alcohol intake.*

*Initially our conversation was coherent. The brother and a nurse assisted with translation. Peter felt very guilty about his first wife and their children, he felt that he had abandoned them to poverty and would like to make it up but his first wife was apparently not responding. Peter was also not very happy with his second wife who appeared to be rather dominant but they loved each other still. He described love as feeling a deep attachment to each other. Peter also experienced a lot of pressure at work, he was a lion feeder in a small game reserve. The management was*

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# Managing Alcoholic Patients

*pressing more and more for quality and he thought that his colleagues were mocking him because he was not circumcised. At his work he and his colleagues used to drink a lot of alcohol. Recently a colleague was severely mauled by a lion and barely survived. Then he told me that he had seen the light, that he had to read the Bible a lot, that he needed to be circumcised, that he should help his first wife...*

*By that time he became agitated and incoherent. I decided to sedate him with Valium 10mg ivi and to lodge him together with his brother and to talk with him the next morning when he should be calm again. My provisional diagnosis was a mild alcohol hallucinosis in a person with many personal problems that had grown out of hand. The next day the conversation went along the same lines ending in agitation again. I suggested that he should be admitted for some time for detoxification and rest, to sort out some of his personal problems, with my support when needed. This was happily accepted.*

*This left me with a problem. I usually don't empathise with alcoholics but Peter struck a chord with me. And with the penetration of the skin by the injection needle for the Valium I felt that I had already committed myself. But I had no idea how to approach him. Hence this study, mainly an abstract of a very useful book I found on addiction problems: 'Hulpverlening bij verslavings problemen', by Minjon and Wolters.<sup>1</sup>*

## Introduction

Alcohol is, or has become, a major problem, for the individual and the community. Literature about this subject can be found in the medical press,<sup>2</sup> as well as in the popular press.<sup>3</sup> Unfortunately textbooks are often superficial<sup>4</sup> or sometimes only

highlighting one aspect<sup>5</sup> or approach<sup>6,7</sup> and are rarely conclusive and practical,<sup>8</sup> especially for rural, black South African situations. The abundance of theories related to alcohol, the problems and the therapy thereof, makes it difficult to work this into a practical and personal application.

## Theoretical Background

A useful definition of alcoholism is: "that situation that exists when a person is so dependent on alcohol that his psychological condition and physical health are notably disturbed, that it has a negative influence on his interpersonal relationships and effectively limits his social and economic functioning." This definition is purposely related to a person's functioning, rather than the amount and circumstances of the alcohol intake.<sup>9</sup>

Jellinek describes 4 phases of alcoholism, acknowledging these as very rough generalisations: pre-alcoholic phase, prodromal phase, critical phase and chronic phase. He also describes 4 types of alcoholics, determined by psychological dependency, physical complications, physical dependency and behaviour deterioration. This division is very rough and the list can be extended *ad libitum*. These types do not necessarily follow each other.<sup>9</sup>

There is also a multitude of etiological theories with a consequent multitude of therapeutic views.

Social studies accept a biologic basis for alcoholism. Some of the results are still disputed but twin studies and studies based on adopted offspring strongly suggest a genetic predisposition towards alcoholism.<sup>10</sup>

**Alcoholism has multifactorial causes.**

# Managing Alcoholic Patients

Psychodynamic theories perceive the alcoholic as an orally fixated person, who finds the bottle a substitute for motherly love. Alcoholism is seen as caused by excessive spoiling and it should modulate aggression towards the parents by the aspects of self punishment and by lessening the inhibition towards symbolical parents, like spouses and authorities. By this it restores a feeling of power. This concept however has become increasingly refuted.<sup>1,10</sup>

The basic hypothesis in the learning-theory is that alcoholism is an acquired, learned behaviour to diminish conditional tension. The secondary feelings of guilt are again drowned by the alcohol; an immediate reward is more preferred over a bigger, but later one. Although acceptable for some persons in certain situations, this theory is not assigned much importance now.<sup>1,10</sup>

Within the socio-cultural perspective it is generally accepted that relationship problems, and even ordinary life events contribute to the development of alcoholism. In the family system theory the victim and the victimisers need each other to maintain an (unhealthy) balance.<sup>3,5</sup> Other identified causative factors include interpersonal conflicts, negative emotional situations, social pressure and cultural changes.<sup>9,10</sup>

It has now generally been accepted that alcoholism has multifactorial causes, that several theories can be applied and therefore that many methods for therapy and rehabilitation are offered. A multi-disciplinary approach is needed and favoured by most.

## Diagnosis

To tackle the problems of alcoholism, one has to consider three aspects: the

discovery of the problem, the motivation of the alcoholic and attitude of the helper, and finally the specific therapies and prevention.

A. *Several factors to justify a suspicion of alcohol problems are recognised:*

- more than average visits to the family practitioner,
- males: multiple and multiform vague physical complaints,
- females: multiple and multiform vague psychological complaints,
- alcohol breath during visits,
- alcohol problems of relatives, eg family members,
- excessive overweight, nausea and loss of appetite,
- marriage problems,
- anxiety,
- depression,
- problems at work,
- multiple minor accidents,
- multiple contact with police,
- complaints from relatives about patient's alcohol use,
- physical complaints caused by gastritis, neuropathy and liver cirrhosis, as mentioned before.<sup>1</sup>

B. *The following step is to make the diagnosis. The most effective is a special question technique: two are very useful.*

### The Cage-method:

- Have you ever felt you ought to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticising 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)?

### The shortened Malt-questionnaire:

- Do you often drink before lunch?

Many approaches in therapy are accepted.

Approach should be non-moralising.

- Would you have less problems without alcohol?
- Do you want to give up alcohol, yet find you cannot do so?

When the questions are answered honestly, two or more positive answers on Cage's and one or more on Malt's questionnaire justify the conclusion of problematic alcohol use.

C. *At this stage a discussion with the patient is needed and the doctor should consider the following:*

- When you conclude that there is "problematic alcohol use", you should report this openly to the patient.
- Ask if the patient can agree with this and ask for his point of view.
- Ask yourself whether you want to discuss these problems with him?
- Does the patient want to discuss these problems with you?
- Does the patient want to work, together with you, on these problems and is he able and prepared to make a plan?
- Does the patient want a follow up appointment, primarily to work out these problems?

## Enablers

The approach must be non-judgmental and one which is not moralising. The doctor must be aware of his own emotional reactions, the effects of his own family system and of the possible influences of the so-called "enablers". One type of enabler is the "helper", who may be compelled by his own anxiety or guilt to rescue the alcoholic from his predicament. Such a person is meeting a need of his own and he can often be a professional with too little insight and/or instruction.

Another enabler is the "victim", who is covering up or justifying all the misdemeanors of the alcoholic's behaviour.

There is also the "provoker", usually the spouse or the mother, who initially accepts the misbehaviour, adjusts to the situation but later unleashes all the bitterness, fear and hurt in the relationship, thereby maintaining the circle.<sup>3</sup>

## Motivation

The motivation of the patient to change is of paramount importance. It is not something static but subject to influences. Demotivating enablers must be identified and neutralised eg incorporated in the therapeutic plan.

Motivation can be stimulated by increasing the positive expectations of the results; small steps forward will enforce the expectations for the final success and therefore encourage motivation.

Motivation can also be reinforced by increasing the cognitive dissonance between the patient's behaviour and his wishes, for instance by giving information about the long-term effects of alcohol, and by enforcing patient's self esteem.

Positive changes when attributed to the patient's own behaviour and efforts, will maintain and increase motivation. Changes through help, outside pressure or coincidence will be less effective.

The previously discussed theoretical models are not mutually exclusive but can be useful tools for understanding and for action. A rather comprehensive work hypothesis combining multiple aspects is that "problematic

Motivation for change is all-important and should be effectuated by a functional analysis.

With intensive therapy about two thirds improve.

# Managing Alcoholic Patients

alcohol use is a combination of different kinds of problematic behaviour, characterised by a drinking pattern often with physical, emotional, cognitive, interactional, social and juridical problems".<sup>1</sup>

When the patient recognises his need for help, a proper assessment must be made of the exact problem:

- the question of asking for help itself; information? help without stopping? help to stop?
- the reason for the question; crisis? slowly developing problem?
- what is the patient's point of view?
- the exact alcohol intake; what? how much? when? where? why?
- a physical examination.
- an inventory of previous efforts and assistance.
- an assessment of the psychosocial situation made on the initial precipitating causes, emotional impact, relational consequences, schooling, work and day programs.

A good way to assess the latter is by means of a functional analysis.

A functional analysis is meant to assess the factors towards, the reaction to, and the consequences of drinking. This is not so much meant to explain as to give a guideline to work on change:

- the precipitating factors: what situations lead to excessive alcohol use? what are the thoughts and emotions around such a situation?
- the maintaining factors (short term): expectations? the real effects: relaxation, avoiding withdrawal effects, suppression of negative feelings, being accepted by a certain group?
- the consequences (long term): guilt feelings, fear for the future, isolation, unemployment, physical problems?

- possibilities for change: self esteem, relation towards helper (dependency?), patient's insight or view of himself, previous attempts to tackle these problems?

As mentioned before, motivation for change is all important and can be seen as the product of the interaction between the drinker, helper and his surroundings. It is important for the helper to avoid stigmatisation and harsh confrontation, to emphasise the individual responsibilities, to show effective empathy and to be prepared to negotiate an approach.

## Therapy

After the assessment a clear plan must be made.

The question whether to aim for total abstinence or limited controlled drinking should not be dealt with in a dogmatic way: there are failures and successes on both sides. It is better to match the required goal to the respective person and his situation. It has generally been accepted that it is difficult to make a realistic evaluation on the effectiveness of the several methods for therapy and rehabilitation. There are no clear conclusions to be made but two things are becoming clear; 2/3 improve with intensive therapy and 1/2 of the alcohol problems are solved without professional help.<sup>1</sup>

In the primary health care setting with non-specialised workers supported self-control procedures are very useful.

Such a procedure has 3 phases:

- self registration and self observation,
- self evaluation,

The doctor should not function like an "enabler" as well.

Most important task of the doctor is to help patient acknowledge his problem.

# Managing Alcoholic Patients

- self reinforcement and stabilisation.

When the patient himself makes a functional analysis he can set a new goal for behaviour: undesired behaviour can be curbed and abandoned, and favourable behaviour can be rewarded. The aim is to:

- influence the decision to drink,
- reduce the causes for drinking,
- change thought processes that maintain the drinking.

Conditions necessary to learn to use this method of self-control procedures are that the patient is able and prepared to monitor his own behaviour, that he is able to set a goal and test his behaviour accordingly, that he must have insight in the functionality of his drinking and that he understands the principles of self conformation.<sup>1</sup>

Alcohol abuse often has functional roots and supportive therapy is needed in the relevant areas; again, a functional analysis can give clues if support is needed on relaxation, sleep pattern, assertivity, relational skills and family contact, underlying depression and self esteem. Here too setting short-term goals can stimulate positive change. The attitude of the direct surrounding, ie family and helper, is of utmost importance, as well as in maintaining the alcohol problem ("enablers"), as in contributing to the solution.<sup>10</sup>

Aversion therapy with disulfiram can sometimes be useful.<sup>10</sup> So is substitution therapy with benzodiazepines, preferably only in extreme cases of short time span.<sup>1</sup> Alcoholics Anonymous can be very helpful as well, in selected cases.<sup>2</sup>

The attitude of both patient and helper towards setbacks and relapses is very important and should be dealt with flexibly. Concepts of reality and lifestyle can enforce or evoke risky situations, whereas special skills to overcome these are not adequate yet. These setbacks must be seen as an event indicative of present weaknesses and therefore as a stimulus to further improvement, or to adjust the goal to a more realistic level or pace, or to enlarge the field of attention.

## Conclusion

A patient's alcohol problem does not need to become a problem for the doctor as well. The major difficulty could be the acknowledgement by the patient of the existence of such a problem.

To assist in this can be the most important task for the doctor. Once the problems are identified, the doctor can, by enforcing motivation and assisting in planning and change, contribute to the rehabilitation of a patient with alcohol problems.

## Finally

- When suspicion arises, active steps can be made to diagnose alcoholism.
- The motivation to change is the most important condition for therapy.
- Self-control procedures are very useful methods to address alcohol problems in Primary Health Care settings.
- A functional analysis enables the doctor to support the patient's change.
- Additional support with life style arrangements, psychotherapy, family interactions, medication and

AA, will be useful in individual cases.

- The doctor must be aware of his possibilities and his limitations in helping an alcoholic.

## Epilogue

*After a week's leave, I saw Peter again, who was half way through our detoxification program. He was very happy; my colleague had organised a circumcision and all his problems were solved. When I confronted him with the other problems and his alcohol use, he responded that those were misunderstandings caused by the translating nurse; the only thing he wanted was the circumcision. I quickly checked this with the nurse involved, who confirmed my initial impression. I couldn't help feeling slightly disappointed and I discharged him with the offer that he was always welcome back when problems would arise again.*

*This study taught me some practical guidelines to approach alcohol problems. Parallel with the steps an addict has to make, the doctor can, by a step-by-step approach, make the therapeutic process less overwhelming and hopeless, and therefore easier to tackle. My personal gut-reaction of antipathy towards alcoholics has not changed but is more manageable and will probably interfere less in the relationship with such a patient in future.*

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