Current Practice

PRACTICAL PSYCHIATRY

Patients with Drinking Problems

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For anyone with a taste for a problem where diagnosis means very much more than writing out the appropriate path. requests—where the basic diagnostic tool is a relationship of trust, and where the required skill is that of reconstructing a history which has as its concern the whole person's physical, mental, and social functioning—this paper proposes a challenge. The challenge is this—to identify the nine out of ten patients with a drinking problem who, on the average general practitioner's list, at present go undiagnosed. This low diagnostic rate is worrying, for excessive drinking is no rarity. The W.H.O. estimate in 1951 was that about 86,000 people in England and Wales suffered from serious and chronic complications of alcoholism, such as alcoholic cirrhosis, with perhaps three times that number drinking to such an extent that alcohol was in some way affecting their lives adversely. A very rough guess today would be that on an average list of 3,000 patients—the possibility of considerable regional, urban/rural variation must be remembered—there are six patients suffering from serious physical consequences of alcoholism and another 24 who are alcoholics or well on the way to alcoholism, while perhaps in only three out of the total 30 cases has their problem been recognized by the patient's general practitioner. The challenge is not only to identify more alcoholics but to identify alcoholism earlier and before the case forces itself on our attention by sadly obvious and sadly irreparable damage.

Definitions

Alcoholism, alcohol dependence, or alcohol addiction is a condition in which the individual has lost control over his drinking or is unable to abstain. The syndrome may be of "bout" or "continuous" form. The basis of such dependence is in part psychological and in part physical, and it is now well established that alcohol is a general cerebral depressant drug able to produce as real and serious a dependency state as, say, the barbiturates.

A senior executive aged 50 was referred at the instance of his firm after a charge of drunk driving. To get himself through a working day he gradually came to rely more and more on the tranquillizing properties of alcohol, and his business life allowed plenty of opportunities for drinking. "Five years ago," he said, "I knew drink was getting on top of me. Tried to cut it down, took someone's advice and laid off spirits for a week or two, but it just all built up again. Dozens of good intentions. Life was very tough at that time, I'd been promoted, I seemed to be working all hours, and really too I suppose, I got into the habit of drinking all hours. Started to be a bit ashamed of the quantity I was drinking, hid it from my friends, my wife. A couple of quick doubles, when nobody else was looking. The question of how to get the next drink seemed very important. I was getting just a bit tight too often—every day, in fact. And I'll admit that quite frequently recently I've needed a morning drink to get me going. Didn't like to talk to anyone about it but I can see now what was happening—drink was no longer something I *wanted*, it was just something *I had to have*, it was just a drug."

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And this sort of story can be repeated endlessly—the housewife who finds she can't leave the sherry alone, the building labourer who after years of heavy beer drinking has become a vagrant meths drinker. Whatever the variations on the theme which the individual story may present the essential features of the alcohol dependent state are few and simple:

(1) A subjective awareness that "drink has become a drug," that a few drinks aren't enough, that one drink leads to another, that any promised upper limit is exceeded.

(2) Withdrawal phenomena. Alcohol is a relatively short acting drug, and withdrawal symptoms therefore come on after only a few hours of abstinence—hence morning withdrawal symptoms such as shakes, sweating, and "butterflies in the stomach." Such symptoms are (quite logically) relieved by more of the drug, and hence the morning drink. Withdrawal fits can occur, and delirium tremens is largely a withdrawal syndrome.

(3) Tolerance phenomena. There is at first a raised tolerance, and then in the later stages of his illness tolerance declines and the alcoholic "begins to get drunk on less."

(4) Amnesias. Alcohol amnesias or "blackouts" are a frequent phenomenon in alcohol dependence. There is no actual loss of consciousness, the patient performs complicated tasks and drives his car home, but in the morning he "can't remember the night before."

Problem Drinking

Problem drinking is a term used to describe abnormal drinking which has not yet progressed (and perhaps never will progress) to the stage of dependence.

"He's vile when he's drunk and nine out of ten Saturday nights he'll be drunk. Hardly touches it during the week—maybe a couple of pints if we go out together. I've known him get into a fight and come back in a dreadful state—I don't know what the neighbours say. And sometimes he's run me short of money." When the patient was seen it was clear that he usually drank quite normally but that on Saturday nights he "reckoned the world owed him a booze-up." He was not addicted and had never experienced shakes or taken a morning drink, but his drinking was certainly a serious problem and threatened to break up his marriage.

Problem drinking is not something to be considered unimportant; and what is labelled problem drinking today may in some years time have declared itself as alcohol dependence. And addiction is not an all-or-none phenomenon—what is called problem drinking would often better be termed incipient addiction. Though the patient may never have taken an early morning drink he may have been in the pub very soon after opening time.

Not to have raised the question of *how much* drink constitutes abnormal drinking may seem strange, but in defining pathological drinking setting an arbitrary quantitative cut-off point between abnormal and normal drinking is not particularly useful. *Drinking is a matter for medical concern when, whatever its quantity, it is causing damage.*

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Knowing When to Inquire

Asking about drinking needs to become more of a routine. There are, too, certain points which if borne in mind may result in the diagnosis not being so often missed.

Blocks to diagnosis which can be avoided are:

Expecting the alcoholic to conform in appearance to the skid-row stereotype. The great majority of alcoholic patients will be well dressed, well shaved, and looking much like any other citizen.

Expecting the alcoholic to be someone with gross physical signs. An enlarged liver will seldom be found, but palpation under the right costal margin will often elicit tenderness. Gross alcoholic neuritis is a rarity, but absent or diminished ankle jerks are a common clue; an obvious tremor is unlikely, but a slight tremor of the outstretched hands or of the tongue may be suggestive evidence. Mild signs of avitaminosis can sometimes be seen. A red face seems rather a naïve sign to mention, and yet it is something which should make one alert.

Forgetting that women, too, suffer from alcoholism.

The alcoholic often comes into the surgery:

Asking for something for "bad nerves." It is perhaps a good rule never to prescribe a sedative, tranquillizer, or anti-depressant without first asking about drinking habits.

Asking for something for "his stomach." Alcoholics suffer from gastritis, and show an abnormally high incidence of peptic ulceration. Again, this may be a good prescribing rule—never give an antacid without inquiry into the patient's drinking.

Asking for "a certificate." Repeated requests for certificates on nebulous grounds should certainly be cause for asking carefully about drinking.

Carrying a letter from a casualty department. Alcoholics are prone to minor accident.

There are certain walks of life which carry risk of excessive drinking, and one should therefore be particularly alive to the possibility of alcoholism when dealing with a patient in one of these jobs. The list includes publicans and licensed victuallers, the catering trade, especially kitchen porters, travelling salesmen, journalists, entertainers, hard-pressed executives, colonial planters, etc., workers in the printing industry, market porters, seamen, casual labourers, and miners and workers in certain heavy industries. A knowledge of the local scene will add other categories to this list.

These specific suggestions should aid in finding the missing 27, but it is probably true here that nothing breeds success like success—once a doctor gets his eye in for diagnosing alcoholism, he suddenly begins to see a lot of alcoholism.

How to Help and How to Motivate

The approach, the details of the way in which the interview is handled, are all important. The doctor has to convey by nuance, by dropped hints and offered cues, that his concern is to help rather than pass judgement, and the agreement between doctor and patient must be to see abnormal drinking as a medical problem rather than as a moral failing.

The first line of inquiry is then to try to establish a picture of the patient's drinking pattern.

Q. Your liver seems a bit tender—I wonder how much you drink—you don't mind me asking—it's something to talk about openly—medical question—when yesterday did you have the first drink?
A. Lunch time.
Q. Opening time?
A. Pretty soon after.
Q. Yes? Give me a rough idea what you had.
A. Say six bottles of beer.
Q. Could it have been more?
A. Well, not more than eight.
Q. Anything else? Spirits?
A. Couple of whiskies.
Q. Again, I know you'll be open with me. . . .

In this way the story evolves of a man who has a stiff whisky as soon as the pubs open, four pints of strong beer in a lunch-time session, a swig from a bottle of spirits in the office during the afternoon, a few drinks at the station buffet on the way home, and an evening session in the pub which goes on to closing time—an addictive pattern begins to emerge. If there is one golden rule in trying to reconstruct a drinking history it is to pay as much or more attention to the patterns as to the amount, and then rather than deal in vague generalities to try instead to chart the exact events of a typical drinking day and the pattern of a typical drinking week.

When this has been gone through, the next stage is to explore the seriousness of the situation and help the patient to accept the reality. Again, careless frontal attack leads only to denial, and at the worst sounds like the caption for an old-fashioned *Punch* joke:

Doctor (not knowing what he means by the term): Do you admit you're an alcoholic?

Patient (not understanding the term any more than the doctor but sensing it's an insult): Certainly not!

Rather than inviting this sort of stone-wall encounter, the strategy must be to discuss with the patient any possible consequences of drinking—he himself thus gradually talks about and builds up the picture of his drinking problem, and perhaps of alcoholism. There is as it were a "hidden agenda" for the discussion at this stage—the doctor must know the headings of the inquiry and work through whatever may be appropriate from certain lists.

Building Up the Picture

Damage to Social Health.—Sensitive inquiry into the effect that drinking has had on a man's social competence is enormously important, and often a few carefully directed questions about money troubles, the effect drinking has had on his job, and how drinking is affecting the way he gets on with his wife and his children, may suddenly make a rather nebulous picture clear.

Q. Drinking ever done you any damage?
A. No, I wouldn't say so.
Q. Ever been late for work because of your drinking?
A. Once or twice recently, I suppose.
Q. Lost a few days from the job because of drinking?
A. That has happened.
Q. Ever been sacked because of drinking?
A. I've always cleared out before they've sacked me!
Q. Has drinking ever caused rows at home?
A. My wife keeps nagging about it.
Q. Has she ever threatened to leave you?
A. Been back to her mother's a few times.
Q. Any debts?
A. Bit behind with the rent and we're in trouble with the H.P.

It is of course vital that such inquiry is conducted kindly, almost casually, rather than as a series of rapped-out questions.

Damage to Mental Health.—The impact which alcohol has been having on the patient's mental health has also to be brought into this discussion with him. As already mentioned, a common reason for the alcoholic consulting his general practitioner is "bad nerves." But there are also many more specific ways in which alcohol can at times affect mental health, and these will be set out in this paragraph as a sort of check list of things to be kept in mind when discussing an alcoholic's troubles with him, though clearly it would usually be inappropriate to work all the way through this list. Abnormal drinking may in fact cause, precipitate, imitate, or be secondary to every known psychiatric syndrome—a case could be made out for today's great imitator being not syphilis but alcoholism. The alcoholic can present with any variety of neurotic symptoms,

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and his abnormal behaviour frequently results in his being diagnosed as a "psychopath" or leads to criminal involvement, though when his drinking has been dealt with so-called "alcoholic personality deterioration" is seen to be reversible. In the setting of alcoholism latent sexual abnormality may become overt. The alcoholic may present with a depressive illness, and alcoholism carries a serious risk of suicide. Alcoholic hallucinosis imitates schizophrenia, alcoholism is a possible cause of dementia (Korsakoff's syndrome or perhaps more commonly a non-specific picture), while delirium tremens is a paradigm of the toxic-confusional state and a diagnosis which is surprisingly easily overlooked if a patient is feverish and is also apparently suffering from pneumonia. Pathological jealousy may be a presentation of alcoholism.

Damage to Physical Health.—The physical complications of excessive drinking are an aspect of alcoholism which are dealt with in textbooks, and will therefore not be considered except briefly. Some review of the impact of drinking on the patient's physical health must of course be brought into discussion with him, though often all that transpires is that he's "not feeling all that fit"; alcoholism should be in the differential diagnosis of non-specific bad health. Trauma, peptic ulcer, and tuberculosis should go higher in any list than hobnail liver, and pancreatitis, hypoglycaemia, alcoholic carditis, and Wernicke's encephalopathy are worth remembering as unusual complications which may catch one out.

And at the end of this preliminary discussion the patient may say that he wants treatment or may still deny his problem. What in either instance can be done to help him?

Helping

Being Able to Help

An alcoholic can be a very trying patient. For being able to help, there are three rules.

Accept Realistic Treatment Goals.—An alcoholic must be advised to be totally abstinent. But anyone who believes that treating alcoholism has as its instant aim the production of lifelong sobriety will soon become disillusioned. The reality is that many alcoholics take a long time in coming round to accepting that drink is their problem, and meanwhile the doctor can help simply by stating that drink *is* the problem, that he is willing to help, and then just playing a waiting game. And though many alcoholics achieve permanent sobriety with remarkably little difficulty others relapse, and relapse again: the patient who relapses still needs help, and help is worth while if it means no more than lessening chaos and bringing a patient out of a drinking bout sooner rather than later.

The Doctor Must Offer a Relationship.—"Offering a relationship" suggests something rather esoteric. In fact it should mean something very simple and very practical—giving the patient the assurance that the doctor feels about him as a human being, so that in consequence the doctor is felt about as a human being and his opinions, approval and disapproval, matter. Every transaction from the initial encounter onwards builds this relationship—what for instance the doctor says (and the feeling he conveys) in the process of such a routine and hurried matter as signing a prescription.

> Yes, I'll give you something for your dandruff. No, you don't need a tranquillizer, you're not going to swop alcohol for pills. . . . If you're feeling anxious and het-up, I'd much rather you dropped in and talked to me for a few minutes at the end of the surgery than that you started taking tranquillizers. . . . You know, it's almost six months now that you've been off drink. . . . I'm really very pleased. . . .

Treat the Whole Situation.—It is usually impossible to help the alcoholic without seeing the wife, understanding her problems, seeing how her behaviour may have contributed to the drinking and may now contribute to the recovery. And with a woman alcoholic it is equally vital to bring the husband into the picture—and no alcoholic, man or woman, can be helped unless one is able to understand something of their work, their leisure, the rewards, anxieties, supports, and threats which their total life is bringing them.

Specific Action

When to Refer for Expert Consultation.—If a patient's drinking problem has progressed to or threatens to progress to a state of dependence it is wise to obtain psychiatric advice, and it may well be wise to get such advice even if addiction has not been established. It is important to realize, however, that, though hospital treatment of the alcoholic often has much to offer, a period of inpatient or outpatient care is never "the answer"—the alcoholic has the lifelong problem of adjusting to a world in which alcohol is plentifully available, in which he has habitually solved his problems by drinking, and in which he cannot now afford to take the first drink.

When to Use Drugs.—Psychoactive drugs have no part to play in the long-term treatment of alcoholism, and the use of barbiturates is contraindicated because of the danger of substituting one dependence for another; chlordiazepoxide is a useful drug for treatment of withdrawal symptoms. Vitamin preparations are indicated only when there is likelihood of there being actual vitamin deficiency and they are not a panacea. Disulfiram (Antabuse) or citrated calcium carbimide (Abstem) should probably only be used after consultation.

When to Use Alcoholics Anonymous.—It is difficult to predict whether a patient will or will not find A.A. useful, and the pragmatic solution is probably to suggest to any patient who is dependent on alcohol that he should go along to A.A. and see "what's in it for him." It is useful for a doctor to have the phone numbers of the local A.A. members of good standing who are willing to act as "sponsors" and introduce a new member. A.A. will oblige by making available some of its literature for the surgery and giving a list of times and places of meetings. Al-Anon is a parallel organization which can give very valuable help to the spouse of an alcoholic.

The Use of Community Resources.—Skill in the use of varieties of community agencies is often needed in helping the alcoholic and his family.

Results

One thing is certain—if the alcoholic is not identified he will not be helped. Finding the missing 27 is important. How do alcoholics respond to the proffered help? About 20% will immediately and gratifyingly accept medical advice and become instantly, permanently, and almost miraculously sober. About 20% will (very tragically) continue to drink despite every effort to help them, and it is at times only kind to tell the distraught wife that everything that medically can be done has been done, and that she may do well to consult the family solicitor rather than the family doctor for her protection. The remaining 60% are not going to be either immediate shining successes or ultimate sad failures—they are eminently worth helping, and help is, if one goes about it the right way and has realistic goals, eminently possible.

FURTHER READING

Jellinek, E. M., *The Disease Concept of Alcoholism*, 1960. Hillhouse Press, Newhaven.

Kessell, W. I. N., and Walton, H., *Alcoholism*, 1965. Penguin Books, Harmandsworth.

USEFUL BOOKS TO GIVE TO PATIENTS

Mann, M., *Primer on Alcoholism*, 1964. Gollanz, London.

Williams, L., *Alcoholism Explained*, 1967. Evans, Bros., London.

USEFUL ADDRESSES

Alcoholics Anonymous Central Service Office, 11 Redcliffe Gardens, London S.W.10 (01-352 9669).

National Council on Alcoholism, 212a Shaftesbury Avenue, London W.C.2 (01-836 0306). This voluntary organization has been prominent in setting up local Alcoholism Information Centres and is very willing to help in education and fostering local community action.

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