MEDICAL PRACTICE

Today's Treatment

Psychological Medicine

Treatment of Alcoholism

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Definitions

Alcoholism is a condition in which the patient's life is dominated by alcohol and he finds he cannot control the amount or frequency of his drinking. The clinician is commonly concerned with two aspects of alcoholism which may co-exist or occur separately: (1) Social, psychological, or physical damage. (2) Signs and symptoms of physical dependence on alcohol.

Some alcoholics have bouts of uncontrolled, damaging drinking, followed by periods of relative abstinence. Others are unable to abstain, may paradoxically never appear drunk, and yet are never without a certain level of alcohol in their system. These chronic tipplers do not conform to the traditional image of "alcoholic," yet they often develop severe withdrawal symptoms when inadvertently deprived of drink—for instance, on admission to hospital.

Prevalence

Alcoholism is common, though ambiguities of definition give rise to variable estimates of its prevalence. A modest estimate would be 400 000 alcoholics in England and Wales with an additional 75 000 in Scotland, where the condition is proportionately more common. Wilkins¹ found in his general practice 6.3 per thousand aged 15-64 were physically dependent on alcohol, and a further 10.3 per thousand had problems arising from alcohol.

Diagnosis

This article is principally concerned with the treatment rather than the diagnosis of alcoholism. Nevertheless, the act of diagnosis itself may be a crucial step in the therapeutic process. Sociologists have been understandably critical of a slavish acceptance of the "medical model" in alcoholism.² They rightly point to the dangers of labelling in this way, for both the individual and those around him. But the moment at which a doctor helps his patients to make a rational appraisal of the part that alcohol plays in his life is of great significance for future management. Recognition that he suffers from alcoholism often helps the patient to make order out of the chaos of his past life and organize his approach to alcohol in the future. The experiences of years fall into place; the stomach pains, the accidents, the loss of friends, opportunities, and money, the bickering and recrimination at home can come to be related to his growing preoccupation with alcohol.

This does not imply that the patient must accept he is an "alcoholic" before treatment can begin. Words like alcoholic should be avoided and the patient rather helped by his doctor to make his own assessment in his own terms of the contribution alcohol has made to his life's problems. As Edwards pointed out in an admirable article on this topic, "a careless frontal attack leads only to denial and at the worst sounds like a 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!

The patient's recognition that he has a drinking problem does not come easily, and several interviews may have to be devoted to building up a realistic picture of his drinking habits. A patient who has been taught that holding one's liquor is a manly virtue will not readily admit that drink has got the better of him. If the patient can come to see the doctor not as a judge but as a

counsellor helping him come to terms with a common but difficult problem, then the therapeutic relationship is under way and may have to be sustained over a prolonged period throughout the subsequent management of the condition.

Domiciliary Treatment

Alcoholics visit their doctors more frequently than other people, and one of these visits will provide an opportunity to open a discussion about drinking habits. Once the diagnosis is suspected the doctor must decide whether to refer his patient to a specialist or other agency. Opinions differ widely on the needs for further referral and on the criteria for such a step. Much will depend on the attitude and interests of the doctor. Pollak⁴ has shown that general practitioners can treat effectively the majority of alcoholics in their practices. There are undoubted advantages in permitting the relationship which allowed the diagnosis to be recognized to continue into therapy itself. Referral can often be interpreted as rejection unless the issue is carefully discussed.

Once a patient has agreed to accept treatment the goal will usually be for him to stop drinking and remain abstinent. Many patients are deterred from stopping drinking because they fear the abstinence syndrome—tremor, restlessness, sleeplessness, and anxiety. These symptoms can be readily treated at home provided the home background is suitably supportive.

The patient should remain at home for three or four days while he abstains from alcohol. Drugs are prescribed during this period to overcome the withdrawal symptoms. The more effectively those symptoms can be relieved at this stage the more impressed the patient becomes at the possibility of medical help for his condition.

TRANQUILLIZERS

Chlordiazepoxide 10-20 mg three or four times a day or chlor-methiazole in a dosage graded to the needs of the patient are both effective in overcoming withdrawal symptoms. It must be remembered that these tranquillizers are for the withdrawal period only and will rarely be required for more than one week. Tranquillizers should not be used for longer-term treatment as there is always a danger of replacing alcohol addiction by some other form of chemical dependence.

HYPNOTICS

These should be used sparingly in the treatment of alcoholism because of the danger of dependence and the increased risk of self-poisoning, which is well recognized in alcoholics. A hypnotic such as nitrazepam is often helpful during the first few days of abstinence.

ANTICONSULSANTS

A small proportion of patients develop convulsions during the abstinence syndrome. This is more likely to develop when withdrawal symptoms have become severe and the patient is in hospital. It is probably best to reserve anticonvulsants for those patients who are known to have developed fits in the past.

VITAMINS

The value of vitamin supplements for alcoholics remains not clear. Those alcoholics who have neglected themselves and for whom alcohol has formed the bulk of their diet will benefit from

vitamins, particularly the B group. But a return to a normal diet will achieve the same goal in most cases.

Having stopped drinking the patient embarks on the more difficult task of remaining abstinent in a society where more than 80% of the population drink regularly. He must make a realistic appraisal of his problems and often face conflicts and decisions which have been avoided through drink in the past. Some doctors will work with the patient throughout his rehabilitation; others may also decide to bring in the social work and voluntary agencies (described later). In either case it is important to recognize the problems of readjustment presented to the alcoholic's family.

ALCOHOL SENSITIZING DRUGS

Once an alcoholic has accepted the need for abstinence he may like to use an alcohol sensitizing drug such as disulfiram or citrated calcium carbimide. They act as deterrents to further drinking because if the patient drinks within three days of taking these drugs he will experience a severe reaction—flushing, palpitations, headache, nausea, and collapse. Severe reactions may require urgent treatment with oxygen and intravenous antihistamines, but most pass after lying down quietly for a few hours. Patients should carry a warning card explaining the dangers. In view of the cardiovascular stress produced by the reaction the drugs should not be given to patients with cardiac disease. Toxic effects reported with both drugs include nausea, rashes, and confusion. Hypothyroidism has been observed with citrated calcium carbimide. These drugs should probably be avoided during pregnancy.

The alcoholic knows that if he takes one of these tablets daily he cannot drink. Some patients find them a useful device, particularly in the early stages, to protect them in the unguarded moment. The patient must have the dangers inherent in taking these drugs carefully explained. He should always be in control of his own dosage. The drug must not be slipped into his tea by a well-meaning wife, a practice hazardous to both his health and his marriage.

During years of drinking the alcoholic husband or wife will have been excluded from ordinary family life, and new patterns of coping without him will have been learned which must slowly be modified as the alcoholic regains his former status within the family. Alcoholism is par excellence a family problem, which challenges the traditional skills of the family physician.

Referral to Hospital

This may be necessary to effect detoxication (drying out) or to offer specialized psychiatric help. Admission to hospital for detoxication becomes necessary either because the withdrawal symptoms are unduly severe or because the patient's social environment is inimical to domiciliary treatment. For instance, it is usually impossible to dry out effectively in the surroundings of a working men's lodging house.

Rapidly worsening agitation and tremor and the development of confusion and hallucinations warrant removal to hospital. Delirium tremens is reported by about 20% of alcoholics, and should be treated in hospital. So should the rarer alcoholic hallucinosis characterized by hallucinations occurring with clear consciousness, often for several weeks after cessation of drinking. These more advanced examples of the abstinence syndrome respond to tranquillizers. The patient should be nursed in a clearly lit ward and regularly reassured. The management at this stage is similar to that for any other confusional state.

The patient should also be assessed for vitamin deficiencies, peripheral neuritis, dementia, cardiomyopathy, anaemia, and liver damage and any necessary treatment given.

Specialized Treatment

Many factors influence the development of problem drinking. The search for a pre-alcoholic personality type has proved fruitless, but the doctor will recognize an interplay of individual *vulnerability* and *opportunity* in most alcoholics' life histories. Most emphasis has been placed on vulnerability, though recently research⁵ has turned to examine the opportunity side of the equation. At its simplest a change of job from barman to shop assistant may be helpful.

Referral for specialized treatment may be prompted by recognition that neurotic conflicts or personality difficulties underlie the patient's drinking or that alcohol is being used as a means of coping with marital disharmony. Thus the emphasis in treatment may be less on the drinking itself than on the personality of the patient.

There are 19 specialized units in England and Wales for the treatment of alcoholism. Most offer group therapy to inpatients in a therapeutic community. This treatment tries to help the patient recognize and modify intrapsychic and interpersonal difficulties so that he is able to cope with a life of abstinence. Initially these services emphasized the importance of admission as an inpatient, but later studies have shown that outpatient management alone can be equally beneficial for some.^{6,7} It seems likely that in future services will be developed more for the outpatient management of alcoholism.

Aversion Techniques

These have found little favour in recent years in Britain, probably because clinicians and patients found them distasteful and lacked evidence that they were superior to other forms of treatment. Recently renewed interest has been shown in techniques of behaviour modification aimed at helping the patient to relearn a socially acceptable pattern of drinking. It is too early to evaluate their effectiveness.

A small but growing number of workers are considering the possibility of a modest return to alcohol at least for some treated alcoholics.⁸ The difficulty here is to predict who can cautiously start again after a period of abstinence. The experiment may be with a man's future happiness or life and is not worth the risk until the findings of research become clear.

Skid Row

Socially deteriorated "skid row" alcoholics form only about 5% of all alcoholics. As a group they have had an undue effect on our stereotype of the alcoholic but surprisingly little positive help from medical services. It is acknowledged that they often prove unresponsive to conventional medical and psychiatric approaches. Many are to be found in the sad queue of drunken offenders who come before the courts each day and are dealt with by fines or short periods of imprisonment. None believe that this "revolving door" is of much value. A Government report⁹ recommended that simple drunkenness should not be a criminal offence and that offenders should be taken by the police to detoxication centres. Studies in Edinburgh have shown that detoxication in hospital is a feasible alternative to prison, a fact already evident in many other countries. An evaluation of the advantages of this approach in Britain is not yet available. Drying out alone offers little if any advance on current procedures unless it is accompanied by a matrix of supporting social work services such as hostels and adequate aftercare.

Teenage Drunkenness

Established alcoholism is rare among adolescents, but there is increasing concern about alcohol abuse in adolescence. Drunkenness offences among youths are increasing rapidly, as is the

incidence of drunken driving. Doctors in casualty departments are often faced with a teenager who has taken a combined overdose of alcohol and drugs. Evidence of alcohol abuse at this age should be a warning sign for the clinician, who should try to help the young person to discuss the part alcohol is playing in his life. It will often be found that such patients have a long history of maladjustment and disturbance, of which excessive drinking is but one symptom.

The Alcoholic's Spouse

Many general practitioners remind the specialist that it is not the alcoholic but his spouse or children who seek help. This is recognized by Alcoholics Anonymous, who have established Al Anon and Al Ateen groups in many areas to offer help and advice to relatives even before the alcoholic accepts his own problem. The personality of the alcoholic's spouse may have a more powerful influence on response to treatment than the patient himself. It is clear that the spouse will require her doctor's help in maintaining a consistent and realistic attitude towards her husband's drinking and, once the problem is accepted, assistance in looking at changes which may be required within the family. A social worker can often help in supporting the family during these changes.

A number of social work and voluntary organizations are of proved effectiveness in the management of alcoholism. The doctor should familiarize himself with the resources in his area, as they will enhance his own therapeutic endeavours. The area specialist in alcoholism should be able to inform his colleagues of these local facilities and help in the co-ordination of available resources. Those which are commonly found are as follows:

ALCOHOLICS ANONYMOUS

This is a well-established self-help organization which stresses that the alcoholic must accept that he is powerless over alcohol and find help in the camaraderie of the group and a daily determination not to drink.

INFORMATION CENTRES

These have been established in some towns to provide help and advice to alcoholics and their families. The centres are commonly administered by local councils on alcoholism.

HOSTELS

These are an essential feature of any rehabilitation programme for alcoholics. Ideally there should be a range of hostels, offering varying degrees of support, from those in which the men learn to establish some degree of independence by living together as an alcohol-free self-help community to self-service flatlets offering nearly total independence.

The Department of Health and Social Security¹⁰ has published guidelines on the ways in which community services for alcoholics may be developed. More recently the Department has established in England and Wales an advisory committee on alcoholism to recommend and promote the development of services for alcoholics. These developments should ensure an increasing range of provisions for them.

Useful Addresses: Medical Council on Alcoholism, 8 Bourdon Street, London W1X 9HV. Alcohol Education Centre, 99 Denmark Hill, London.

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Hospital Topics

Family Unit in a Children's Psychiatric Hospital

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Summary

The need for effective management of disorders of parent/child relationships is repeatedly stressed. Despite the bulk of theoretical work on the subject there is little information on the practical management of the clinical problems that arise. We describe a unit designed and staffed for the management of such disorders. In our view it meets a need in a way that could be difficult or impossible for most paediatric, psychiatric, and social services as they are at present organized.

Introduction

Inpatient facilities for the assessment and management of problems that arise between parent and child are uncommon despite the importance of family interrelationships in all aspects of child health. There is also growing concern about some specific clinical problems, particularly child neglect and abuse, but little information on constructive methods by which such problems can be met.

For the past eight years the Park Hospital has been admitting mothers with their children and concentrating on the psychotherapy of the family problems that underly baby battering and the distress generated in the families of children with developmental disorders. Altogether over 250 families have been admitted. The hospital has 30 beds for children with psychiatric abnormalities, epilepsy, and other developmental disorders and was opened in 1958. In 1964 a unit for mothers was built.

Mothers' Unit

The unit is a modern bungalow set in a garden a few yards from the main hospital building and shares with it pleasant park-like

grounds (see fig.). It has bedrooms for three mothers and communal domestic facilities. There is room for the child and any siblings to stay with mother or the children may sleep in the main hospital nursery. The hospital contains departments appropriate for a developmental medicine unit, including bedrooms, nurseries, occupational therapy, psychological and electroencephalographic facilities, and a school. Children are also admitted without their mothers to the main hospital. The age range of children admitted is from birth to early adolescence; the mother-and-child unit is concerned mainly with the younger age groups.

Mother-and-baby unit.

Staffing

A consultant with paediatric and psychiatric experience is in overall charge and supervises the two senior registrars who manage the unit on a day-to-day basis. One senior registrar's basic training is in psychiatry and the other's is in paediatrics. A nursing sister with an assistant takes a special interest in the unit and its children, as do a senior occupational therapist, a psychologist, and a social worker. This team is usually joined by a community social worker who is already or will be dealing with the family's case.

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