Alcoholism in a Shot Glass

TREATMENT METHODS FOR ALCOHOLISM

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Treatment Methods for Alcoholism

Treatment of alcoholism must be multifaceted because alcoholism is a *biopsychosocial disorder*. Treatment must be aimed at every known facet of the disease. Alcoholics and their particular alcoholisms have great commonality, but they are also unique; therefore, treatment must be aimed at both the commonality or universality of each alcoholic's alcoholism and the uniqueness or individuality of the way in which the disease affects the person seeking help. Treatment strategies can have medical, educational, psychological, and social components. Detoxification and treatment of alcohol-induced anemia are examples of medical components of a treatment plan. Lectures on the effect of alcohol on the

brain and nutritional counseling are examples of educational components. Group therapy and individual counseling are psychological components. Use of a structured or semistructured environment (such as, a halfway house) and participation in a self-help program are social components. Self-help groups work in complex ways and are both psychological and social modalities of treatment.

Treatment can be conceptualized as tripartite: treatment of the active alcoholic, treatment of the early-sobriety alcoholic, and treatment of the stably sober alcoholic. Alcoholism counselors usually handle the first two parts. Since this book is written for counselors and counseling students, its emphasis is on psychological treatment methods, or interventions. The

word *intervention* is used in two senses. A *psychological intervention* is an action taken by a counselor or therapist does in the course of treatment (for instance, confronting an alcoholic about his or her alcoholism). Psychological intervention refers both to individual events—the particular things said by the counselor—and to categories or types of interventions. “Your blacking out last night is a symptom of alcoholism” is an intervention. It is both *confrontational* and *educational*. Other categories of psychological intervention are *clarification* (“Tell me more about that”); *labeling of affects* (“You are angry”); and *interpretation* (“Your drinking, whatever else it means, is an act of rebellion,” “an identification with your father,” or “a means of self punishment”). In alcoholism counseling, intervention also means a planned

confrontation of an alcoholic about his or her alcoholism by family, friends, and sometimes an employer for the purpose of getting the alcoholic to enter a treatment program. Such an *alcoholism intervention* is usually arranged and managed by a professional interventionist who is likely to be an alcoholism counselor.

TREATMENT OF THE ACTIVE ALCOHOLIC

Psychological treatment of the active alcoholic has three principal components: diagnosis, confrontation, and education. Psychological treatment alone is often insufficient; medical, nutritional, and social treatment also may be needed. In any case, the first step is diagnosis. Diagnosis is sometimes obvious, as in the case of a man in delirium tremens who has cirrhosis

and who was fired from his last three jobs for excessive drinking. Sometimes it is far from obvious, as in the case of the brain surgeon who drinks four martinis and a bottle of wine each night but who is otherwise functional and healthy and seemingly relates satisfactorily to others. Alcoholics are diagnosed in many different ways by many different kinds of people. Alcoholics Anonymous says that alcoholism is a self-diagnosed disease, and in a sense it is: unless the alcoholic accepts the diagnosis, treatment is futile. Alcoholism is often diagnosed by spouses, other relatives, friends, employers, clergy, physicians or other professionals, or even by acquaintances long before self-diagnosis occurs. Alcoholism is “the disease that tells you that you don’t have it,” and denial is intrinsic to it— hence the need for diagnosis by others.

Although alcoholism counselors often deal with people who have already been diagnosed as alcoholic, they are also asked to evaluate, or assess, persons whose drinking behavior or the meaning of whose drinking behavior is unknown. Although structured interview techniques may be used, a careful and systematic history taking will elicit considerable information about a person's drinking behavior and its consequences. Such diverse behavior and objective signs as Monday morning absences from work, morning shakes, blackouts, interpersonal conflicts, *spider angioma* (the characteristic patch of red lines seen on the faces of heavy drinkers), elevated liver enzymes, depression that does not remit with appropriate treatment, increasing and inexplicable fears, neglect of personal hygiene, and otherwise

unexplained social withdrawal can be symptoms of alcoholism. Of course, they can also be symptoms of other disorders. What the counselor looks for is a pattern. The more symptoms a person shows, the more likely that alcoholism is present. A family history of alcoholism greatly increases its probability, and the closer the alcoholic relative, the greater the risk factor.

Building trust is important; clients who trust their counselors and patients who trust their therapists tell them their secrets, and in doing so they often tell themselves what they knew yet did not know—that they were drinking alcoholically.

Research on biological markers for alcoholism may eventually yield laboratory tests to diagnose some forms of alcoholism, perhaps before they become

manifest, so that preventive measures can be taken. But for now, careful assessment by a physician, therapist, or counselor is necessary for diagnosis. Once the diagnosis is made, treatment follows. Since alcoholism entails the ingestion of a highly toxic substance over an extended period of time, a comprehensive medical examination is always in order. A medical examination will indicate whether detoxification is necessary. If so, the physician must decide whether it is best accomplished on an outpatient or an inpatient basis. This should *always* be a medical decision and should never be made by a nonmedical counselor or therapist.

DETOXIFICATION

Detoxification is the medical management of withdrawal from a depressant drug with the fewest

possible adverse consequences. It is not in itself a treatment for alcoholism. Detoxification can be accomplished in many different ways, but, as noted in chapter 3, all involve the substitution of another sedative-hypnotic drug for alcohol and then gradual reduction of the dosage of the substituted drug to zero. This is done over a period ranging from three to ten days, with four or five being the usual.

Detoxification can be accomplished on an outpatient or inpatient basis. Many people can withdraw from alcohol without medication; they are uncomfortable but not in danger. Getting over a bad hangover, is a familiar example of nonmedical withdrawal, although a hangover results from alcohol's toxicity as well as its withdrawal. Some people can be

safely detoxified with medication and social support; others require the facilities of a hospital.

Librium is the drug most commonly used for detoxification. Pentobarbital, paraldehyde, and other sedative-hypnotic drugs also are used. In addition to Librium, patients are sometimes given anticonvulsive agents such as Dilantin, shots of vitamin B_{12}, other nutritional supplements, and sleeping medicines such as Chloral Hydrate. Librium is an anxiolytic, or antianxiety, drug. Librium has addictive potential and should not be prescribed for alcoholics after they have withdrawn. The same is true for other minor tranquilizers such as Valium, Miltown, and Xanax. Cross-addiction between alcohol and antianxiety drugs is common.

The medical and psychiatric complications of alcoholism are often diagnosed during inpatient detoxification and their treatment is then begun. Depression is often caused by alcoholism, and it should not be treated psychopharmacologically until the alcohol has been cleared from the alcoholic’s mind and body. Depression usually remits with abstinence. As soon as the patient is well enough, education about alcoholism should be initiated. At the same time, the detoxifying patient’s denial should be empathically confronted, and a plan to sustain recovery should be worked out with the patient. If possible, exposure to AA should be arranged. Even if the patient decides not to affiliate with the “program,” acquaintance with it gives the patient an important option. Social support is important during detoxification, and reassurance is

certainly indicated especially for someone experiencing severe withdrawal symptoms. Patients experiencing DTs may need to be restrained to prevent injury to themselves or others.

Outpatient detoxification is best for a patient whose alcoholism is not too severe and who has an intact support system. Inpatient detoxification is indicated if the patient has been drinking heavily, especially if for a long time. If the patient is known to have medical complications or is otherwise debilitated, inpatient detoxification is clearly best. An alcoholic with a history of seizures or DTs should be hospitalized. Another factor in favor of hospitalization is its provision of external control. This is sometimes necessary to get a patient to stop drinking. While the

alcoholic is an inpatient, he or she cannot drink, and thereby time is bought in which to initiate a recovery program; this time can be used for therapeutic interventions.

USE OF ANTABUSE AND NALTREXONE

Antabuse is the trade name of the drug *disulfiram*. Disulfiram blocks the conversion of acetaldehyde into acetate (see discussion in chapter 1), and the blood level of acetaldehyde, the highly toxic first metabolite of alcohol, rises. This quickly makes the drinker acutely, and possibly seriously, ill. Although there can be side effects with Antabuse, they are unusual and in most cases, the alcoholic on Antabuse feels no effect of the drug unless he or she drinks. Nevertheless, disulfiram use must be carefully monitored. It inhibits a

variety of enzymes including dopamine beta-hydroxylase, possibly resulting in increased dopamine activity which can precipitate a psychotic episode. There are many medical and psychiatric conditions in which disulfiram is counterindicated. The intensity of the Antabuse-alcohol reaction depends on the dosages of both, but even minute amounts of alcohol will make the drinker taking Antabuse ill. Reactions include sweating, dizziness, feelings of impending doom, chest pain, vomiting, shortness of breath, and falling blood pressure. If the Antabuse level is high enough, severe cardiovascular symptoms and even death may ensue. Doses lower than those prescribed in the past are now used, and dangerous reactions are thus much less common.

Alcoholics put on Antabuse are thoroughly instructed on the alcohol-Antabuse reaction and told to take their medicine each morning. Sometimes the Antabuse is administered by a nurse or other health care worker in a facility such as a halfway house. Other times it is self-administered, usually by an alcoholic who is motivated to become abstinent but who fears his or her lack of impulse control. If the alcoholic wishes to resume drinking, he or she must go off Antabuse and wait three to seven days, depending on the dosage, before he or she can drink without becoming ill. This prevents impulse-driven lapses of abstinence. The success rate of Antabuse therapy is unknown. A recent NIAAA (1988) study showed that patients on Antabuse did no better than a control group, but like all such studies, this does not indicate

which alcoholics in the sample benefited or how to select those most likely to benefit from the treatment. Obviously, patients on Antabuse can plan slips and stop taking their medicine and some do. For others it serves as an external control until internal ones can be established. It would seem to be a treatment of choice for the medically intact drinker who is motivated to stop but who has, or fears, poor impulse control. Since Antabuse is usually used with patients who have been unable to achieve stable sobriety any other way, it is not to be expected that the success rate will be high. Patients usually stay on Antabuse for six months to a year, and some use it during times of stress even after years of sobriety.

Antabuse therapy should not be used alone; it

should be an adjunct to counseling and to participation in a self-help program. The counselor needs to explore with the patient the meaning of taking the drug. Is the drug experienced as an impingement or violation; as a self-protective action, like securing a safety belt in a car; as a magical talisman, a security blanket that is not part of the self; as an internal punitive, withholding parent; or as an internal loving, limit-setting parent? Both sides of the alcoholic’s ambivalence toward Antabuse need to be uncovered. The decision to take Antabuse may be as important as its actual ingestion; it constitutes a considerable commitment on the part of the drinker.

Naltrexone, an opiate antagonist that blocks highs, has long been used in the treatment of heroin

addiction. More recently, it has been adapted to the treatment of alcoholism. Early results have been promising, suggesting that Naltrexone, which is said to reduce cravings, is a useful adjunctive treatment as one component of a comprehensive rehabilitation plan for alcoholics.

ABSTINENCE VERSUS CONTROLLED DRINKING AS A TREATMENT GOAL

The longer an alcoholic has been drinking, the less likely it is that he or she can return to social drinking. Many alcoholics have never been normal social drinkers. Few people are able to move from problem drinking of any duration and severity to normal social drinking. The goal of therapy with the vast majority of alcoholics must therefore be abstinence. There are

some exceptions. Total abstinence is not a realistic goal with some adolescent substance abusers, who are not necessarily prealcoholic, nor is it a realistic goal with some late middle-aged alcoholics who have been abusing alcohol for many years but who have reached a relatively stable intrapsychic and interpersonal adjustment and whose relationship to alcohol is also relatively stable. Abstinence remains the treatment of choice with these patients too. If abstinence proves to be untenable, then helping the adolescent deal with developmental issues or helping the aging drinker minimize binges and express feelings, especially rage, in a more adaptive way may be the best that can be done. These are exceptions, however; complete abstinence must be the treatment goal with the overwhelming majority of active alcoholics.

Some behavioral psychologists (Sobell & Sobell, 1978; Marlatt & Gordon, 1985) disagree with this, opting instead to attempt to recondition their clients to drink normally by using a variety of classical conditioning, instrumental conditioning, social learning, and cognitive-behavioral techniques. The research evidence does not support the use of this approach, except with a few carefully selected patients. The problem is that we do not know how to predict reliably which alcoholics can be successfully treated with these methods. Problem drinkers who may not be alcoholic are better candidates for behavioral treatments with controlled drinking as their goal. (See Levin, 1991, for a discussion of problem drinking as distinguished from alcoholism.) The Sobells (1993) have now made a clear distinction between alcoholics

and problem drinkers. In their view, 5% of the adult population is alcoholic (severely dependent on alcohol), while 20% of the population are problem drinkers. Citing the survey research findings that alcohol problems come and go (see chapter 4), they deny that alcohol problems are progressive and have devised a social psychological-cognitive behavioral treatment for problem drinking, which they call a "self-management approach." This approach uses self-monitoring forms, behavioral logs, and homework assignments.

Risk Management, also known as *least harm theory*, holds that any treatment that reduces the harm addicts, including alcoholics, do to themselves is worth doing. From this point of view, convincing intravenous

cocaine users to smoke crack would be seen as a positive outcome. Although this paradigm is usually applied to multiaddicted populations, there are alcoholism specialists who view reducing the client's intake as a highly worthwhile goal. The therapeutic goal of controlling drinking can be seen as a form of risk management treatment.

Some behavioral therapists use various forms of *aversive conditioning*, in which drinking is paired with punishment in a classical conditioning paradigm, with the goal of abstinence. The research evidence is not conclusive on the efficacy of aversive conditioning in treating alcoholism, but it clearly takes extraordinarily motivated patients to subject themselves to this treatment.

Some psychoanalysts believe that an alcoholic should be able to drink normally after a successful analysis. It is now known that there are both innate biological factors, at least in some cases of alcoholism, and acquired biological factors, such as changes in brain chemistry, that mitigate against such an outcome, and that analysis will not change either. Besides, it is amazing how unimportant, or even undesirable, drinking becomes to most successfully rehabilitated alcoholics.

What about the alcoholic for whom alcohol meets vital psychological needs and who does not do well in sobriety? It is the purpose of psychological treatment, including counseling, to change this state of affairs, and it usually does. Very few alcoholics are worse off when

they are sober, and those who are tend to be near-psychotic or overtly psychotic drinkers who need psychotropic medication to do what they hoped alcohol would do. With these exceptions, if the counselor helps the alcoholic mourn the loss of alcohol and find alternative and more adaptive means of satisfying emotional needs, the alcoholic will not feel worse when sober. Quite the contrary, overcoming an addiction increases self-esteem and inevitably raises the recovering alcoholic's level of functioning. If depression persists after several months of sobriety, the answer is not to return to drinking (although the alcoholic usually thinks so), but instead the depression must be treated psychologically, psychopharmacologically, or both. In these cases depression is not caused by drinking and must itself be treated before the alcoholic

can enjoy sobriety.

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