

Brief Intervention for Alcohol Problems in Primary Care

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Introduction

In the United States, alcohol abuse is widespread and appears to be on the rise in some locales, resulting in increasing hospitalization and medical resource use.¹ In metropolitan Chicago, IL, for example, the average length of hospital stay for drug and alcohol treatment was 3.5 days at a cost of \$3390.¹ Almost 50% of the patients who present to a family care practice have some form of alcohol or drug disorder,² and an estimated 20% of patients seeking hospital and outpatient care are either experiencing or at risk of experiencing some alcohol-related difficulty.³ Thus, primary care physicians have tremendous opportunities to provide appropriate education and treatment for patients who abuse alcohol. Physicians must be familiar with the treatment modalities that facilitate detection of the disorder and effectively alter patient behavior. Alcohol screening methodologies, such as the guidelines published by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Figure 1), are appropriate and should be adopted by all primary care physicians when obtaining routine patient histories. Despite the importance of alcohol screening, physician utilization of such screening methodologies to detect alcohol abuse and alcohol-related problems is extremely low: studies show that less than 25% to 50% of patients report being questioned about their alcohol use during medical encounters.^{4,5}

Efforts to mitigate the effects of alcohol on individuals with abuse problems are extensive. Three major modalities should be familiar to primary care physicians: the 12-session Cognitive Behavioral Therapy (CBT), the four-session Motivational Enhancement Therapy (MET), and the 12-session Twelve Step Facilitation (TSF). CBT focuses on the clinician's use of social learning principles to abrogate the patient's abuse of alcohol: the patient's alcohol abuse is viewed as an inappropriate coping mechanism and the patient

is trained in cognitive and behavioral skills in order to maintain sobriety and prevent relapse.^{6,7} MET uses motivational psychology and natural recovery processes to activate self-changing processes in the patient; this self-change allows the patient to call upon her or his own capacities and resources to resolve alcohol-related problems.⁸ The MET process may involve a spouse or other partner in the patient's life.⁹ TSF is the common method used in Alcoholics Anonymous (AA), and this modality encourages patients to adopt the basic premises of AA and obtain behavioral objectives to assist in self-control in a supportive environment.¹⁰

The efficacies of these treatments appear similar¹¹ and previous reports indicate that costs of alcoholism treatments do not appear to be related to outcomes.¹² However, because the current United States health care delivery system continues to search for methods to reduce costs, these three treatment programs have been compared financially. In a research setting in which the three modalities were assessed over a 12-week period, the study concluded that, per patient contact hour, MET cost at least twice as much as CBT or TSF; however, per research participant overall, MET was less costly because of the relatively fewer sessions.¹³ When the same assessment of costs is made outside the research setting, the conclusion is similar;¹³ however, the nonresearch setting showed tremendously reduced costs for each modality, most likely because of the high training and research costs associated with a clinical trial. In addition, the differences between each program's costs were lower in the nonresearch setting than during the relative treatment period.¹³ Treatment

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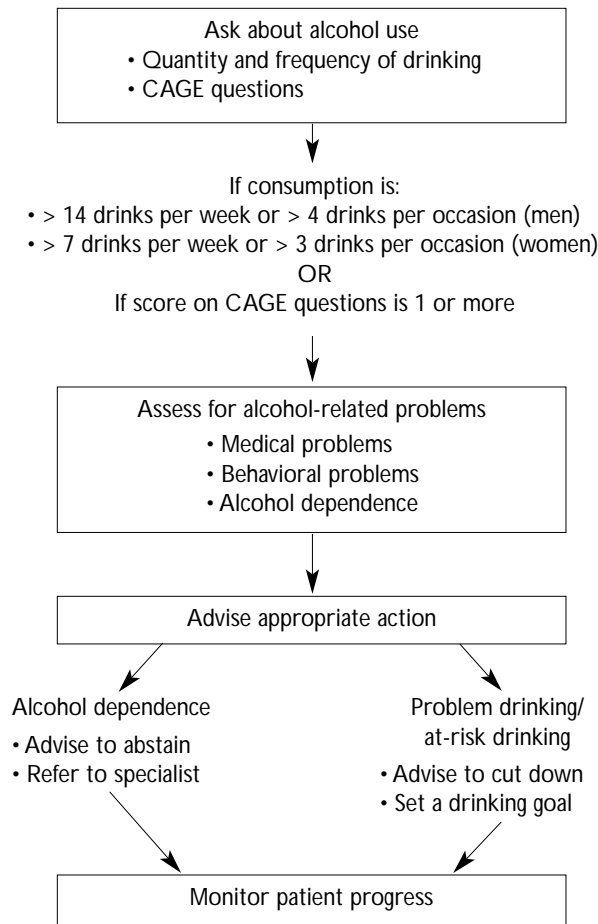


Figure 1. Alcohol screening and brief intervention for physicians. Adapted from National Institute on Alcohol Abuse and Alcoholism: *The Physician's Guide to Helping Patients with Alcohol Problems*. Washington (DC): National Academy Press, 1995.

studies examining differences in the length of inpatient hospital stay found that shorter treatment periods did not necessarily have an adverse effect on outcome; the key characteristic associated with success was post-treatment program attendance in aftercare programs.¹⁴ Although these programs focus on abstinence from alcohol, some reports indicate that a focus on control or moderation of alcohol use can be successful as well.^{15,16}

Other assessments of alcohol treatment programs in managed care are ongoing.¹⁷ This focus on the managed care setting appears appropriate because it has been reported that the managed care system may not adequately provide treatment to patients who abuse alcohol;¹⁸ the system may also have adverse effects upon the children of alcoholic patients, who cannot obtain necessary services, counseling, and treatment.¹⁹ Further,

Table 1. Questions to Ask Patients About Alcohol Use

Ask all patients:

- Do you drink alcohol, including beer, wine, or distilled spirits?
- When was your last drink?
- Have you ever had a drinking problem?

Ask current drinkers about the quantity* and frequency of alcohol consumption:

- On the average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks that you have had on any given occasion during the last month?

Ask current drinkers the CAGE questions about the patterns and consequences of their alcohol consumption:

- C** Have you ever felt that you need to **C**ut down on your drinking?
- A** Have people **A**nnoyed you by criticizing your drinking?
- G** Have you ever felt bad or **G**uilty about your drinking?
- E** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (ie, an **E**ye-opener)?

*One drink is defined as 12 oz of beer, 5 oz of wine, or 1.5 oz (one jigger) of distilled spirits.

Adapted from National Institute on Alcohol Abuse and Alcoholism: *The Physician's Guide to Helping Patients with Alcohol Problems*. Washington (DC): National Academy Press, 1995, and Ewing JA: Detecting alcoholism: the CAGE questionnaire. *JAMA* 1984;252:1905-1907.

because of increasing costs, coordination between inpatient and outpatient programs appears to be diminishing in employer-based, managed care programs,²⁰⁻²² which increases the specter of alcoholic relapse.

It is apparent, however, that problem recognition is the first and most important step in mitigating the extensive medical and social effects of alcohol abuse. Routine screening of alcohol use through a methodology such as the CAGE approach (**Table 1**) used in this case study is essential; the primary care physician's incorporation of the CAGE assessment into a normal examination process can assist tremendously as patients begin to take control of their lives. Indeed, simply asking patients about alcohol use may cause them to reduce their levels of drinking.²³ In addition, in this cost-sensitive medical care environment, early detection and treatment of the alcoholic patient has

been shown to stem the high and rising treatment costs by more than 50%.²⁴ These results indicate the great human and pecuniary value for primary care physicians to be vigilant about screening their patients for alcohol use and abuse.

CASE PRESENTATION

Initial Presentation

A 30-year-old woman presents to her new primary care physician following enrollment in a new health insurance plan. She is requesting a routine annual preventive health examination and a refill of a prescription for birth control pills.

History

The patient has no current medical complaints and her medical history is unremarkable except for minor, self-limiting health problems. Her mother, father, and brother are in good health and there are no significant familial diseases. The patient is married, but her husband of 6 years has been stationed overseas for military duty for the past 6 months. They have no children. Since finishing college, the patient has worked as an assistant branch manager of a major bank. She follows a diet that includes adequate amounts of protein and plenty of fresh fruit and vegetables, but she does not exercise regularly. The patient smokes approximately six packs of cigarettes per week. When asked about current alcohol use, she admits to daily drinking but is nonspecific about the quantity and frequency of her drinking.

QUESTION

- **How should screening for alcohol problems be incorporated into history taking?**

DISCUSSION

Approaches to Screening

Primary care physicians should screen all patients for alcohol problems. Screening should be incorporated into the history with other routine questions and should involve a precise history of patient alcohol use and/or the use of standardized screening questionnaires.²⁵ The physician should not accept vague answers if the patient becomes evasive.

Although every physician has a unique style and the most appropriate question to ask first varies with the clinical situation, evidence suggests that asking direct questions can effectively and efficiently elicit information about drinking habits.²⁶ Questions to ask patients about alcohol use are listed in Table 1. All patients should be questioned initially about whether they drink alcohol. Current drinkers should also be asked

about the quantity and frequency of their alcohol consumption. One drink is defined as 12 oz of beer, 5 oz of wine, or 1.5 oz (one jigger) of distilled spirits.

Several short and easily administered questionnaires are available that allow for the rapid screening of problematic alcohol consumption. The most widely promoted screening test for use in clinical practice is the CAGE questionnaire (Table 1),²⁷ which uses four questions to assess patterns and consequences of alcohol use. The sensitivity of the CAGE questions for identifying lifetime alcohol problems ranges from 60% to 95% using a cutoff set at two positive responses. The Alcohol Use Disorders Identification Test (AUDIT)²⁸ is a 10-question multicultural screening tool for the early identification of problem drinkers. The Short Michigan Alcohol Screening Test (SMAST) also assesses for the lifetime consequences of alcohol use.²⁹ Although used in research settings, AUDIT and SMAST can be cumbersome to use in primary care.³⁰

FURTHER QUESTIONS ABOUT ALCOHOL USE

Because the patient is evasive when asked about the quantity and frequency of her drinking, the physician asks the CAGE questions. The patient acknowledges that she has tried to cut down on her drinking recently and has felt guilty about her drinking, tearfully admitting to an extramarital liaison that occurred during a blackout after consuming "at least six" drinks at a bar several weeks ago.

QUESTION

- **Based on this patient's history and answers to screening questions, how should she be classified for further assessment?**

DISCUSSION

Classification of Alcohol Use

After obtaining a routine medical history and asking initial screening questions for problem drinking, it is helpful to classify a patient's pattern of alcohol use on the basis of health risks. The NIAAA classification system is summarized in Table 2. Designed to be an initial assessment procedure and not a diagnostic tool, the NIAAA classification encompasses a broader range of drinking behaviors than the dichotomous scales for alcohol abuse and dependence outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*.³¹

The NIAAA defines *low-risk drinking* as no more than 14 drinks per week or 4 drinks per occasion for men and no more than 7 drinks per week or 3 drinks per occasion for women. Low-risk drinkers answer negatively

Table 2. National Institute on Alcohol Abuse and Alcoholism Classification of Patterns of Alcohol Use

Classification	Indicators
Low-risk drinking	No drinking in risky situations (eg, before driving or operating machinery) AND alcohol consumption that does not exceed 14 drinks per week or four per occasion (men) or seven drinks per week or three per occasion (women)
At-risk drinking	Drinking in risky situations or drinking in excess of recommended low-risk levels OR drinking when the patient has a personal or family history of alcohol-related problems
Problem drinking	Drinking in risky situations or drinking in excess of recommended low-risk levels or evidence of alcohol-related medical or behavioral problems OR one or two positive responses to the CAGE questions that have occurred within the past year
Alcohol dependence	Three or four positive responses to the CAGE questions OR evidence of one or more of the following: Preoccupation with drinking Compulsion to drink Impaired ability to control the amount of drinking Increased tolerance to the effects of alcohol Symptoms of withdrawal after cessation of drinking

Adapted from National Institute on Alcohol Abuse and Alcoholism: *The Physician's Guide to Helping Patients with Alcohol Problems*. Washington (DC): National Academy Press, 1995.

to all four CAGE questions and do not have a personal or family history of alcohol-related problems. *At-risk drinkers* exceed the recommended limits of low-risk drinking. Patients who drink in risky situations (eg, before driving) or who have a personal or family history of alcohol-related problems but are not currently experiencing any biopsychosocial problems related to drinking are also classified as at-risk.

Problem drinkers drink in excess of the recommended low-risk consumption levels, may give one or two positive responses to the CAGE questions, and have evidence of alcohol-related medical, behavioral, or social problems. *Dependent drinkers* typically give three or more positive responses to the CAGE questions and exhibit a maladaptive pattern of alcohol use evidenced by habitual compulsive drinking (drinking for the mood-altering effects of alcohol), impaired control over drinking (unable to stop drinking once started), relief drinking (using alcohol to treat anxiety, depression, or insomnia), chemical dependency (drinking to avoid withdrawal symptoms [eg, tremors, nausea, sweats, mood disturbance]), and increased tolerance (using more alcohol to achieve a certain desired effect).

Classification of This Patient

Based on her initial responses, this patient would be classified as a problem drinker. Her drinking exceeds low-risk levels, she gave two positive responses to the CAGE questions, and she is experiencing psychological distress resulting from her drinking as evidenced by tearfulness over sexual indiscretions.

QUESTION

- **What health-related problems are associated with alcohol abuse and how should patients be assessed for these problems?**

DISCUSSION

Biomedical Problems

Alcohol can cause damage to virtually every tissue and organ system of the body,³² but its toxic effects depend on the quantity and frequency of alcohol consumption and a patient's gender, age, and nutritional status. Excess alcohol consumption is a risk factor for hypertension, heart failure, and stroke. Alcohol is toxic to nervous tissues and leads to dementia and peripheral neuropathy. The liver is the organ most commonly affected by alcohol because the liver receives portal blood containing high concentrations of alcohol directly from the intestines and, as the primary site of alcohol metabolism, the liver forms abundant toxic alcohol metabolites. Excessive alcohol consumption causes acute liver injury (alcoholic hepatitis) and a chronic progressive form of liver injury (fibrosis or cirrhosis). Alcohol abuse is the leading cause of liver-related mortality in the United States and the eleventh leading cause of death, accounting for more than 25,000 deaths in 1992.³³ Because less than 50% of heavy drinkers develop alcoholic hepatitis or liver fibrosis, other environmental factors and genetic susceptibility are thought to interact with alcohol to produce liver disease.

One of the most serious effects of excessive alcohol consumption by pregnant women is fetal alcohol syndrome (FAS). The syndrome is characterized by

Table 3. Problems Associated with Excessive Alcohol Use or At-Risk Drinking

Biomedical Problems			
Symptoms	Signs	Illnesses	Laboratory abnormalities
Headache*	Hypertension*	Gastric reflux	Elevated liver enzymes (especially gamma-glutamyltransferase)
Nausea*	Arrhythmias	Gastrointestinal bleeding*	Increased mean corpuscular volume (macrocytosis)
Dyspepsia*	Spider nevi	Pancreatitis	Hyperlipidemia*
Palpitations	Seizures	Fatty liver*	Hyperglycemia (glucose intolerance)
Abdominal pain*	Recurrent trauma*	Alcoholic hepatitis	
Recurrent diarrhea	Malnutrition	Hepatic fibrosis/cirrhosis	
Nervousness*	Testicular atrophy	Cardiomyopathy	
Anorexia*	Hand tremor	Peripheral neuropathy	
Recurrent minor illness*	Parotid swelling	Preterm labor	
Impotence	Gynecomastia*	Fetal alcohol syndrome	
Reduced libido*			
Psychological/Psychiatric Problems			
Sleep disturbances*	Eating disorders	Wernicke's encephalitis	Excessive medical care*
Depression*	Sexual dysfunction	Korsakoff's psychosis	Marital problems
Suicide gestures	Memory problems	Personality problems	Child neglect/abuse
Adjustment disorders*	Blackouts	Dementia	Elder neglect/abuse
Social Problems			
Poor school or work performance*	Social isolation	Public intoxication	Domestic violence
Under/unemployment	Loss of friends	Driving while intoxicated	Assault/battery
Financial problems	Criminal activity		

*Commonly seen in primary care.

prenatal and postnatal growth retardation, central nervous system disorders (structural abnormalities, developmental delay, intellectual impairment), and facial anomalies (short palpebral fissures, thin upper lip, flattened midface, indistinct philtrum). Abel³⁴ estimated that FAS occurs at a rate of 9.7 per 1000 live births in the general population and in 4.3% of children born to women who drink heavily, or about 2000 cases annually in the United States.

Psychosocial Problems

In addition to the major medical diseases associated with problem drinking, a broad spectrum of psychiatric and behavioral problems occur in this population (Table 3). Nearly all patients who abuse alcohol have symptoms of anxiety and a depressed mood. These symptoms may be caused by the direct sedative and depressive effects of alcohol or the adverse social consequences of alcohol abuse. Patients who have a docu-

mented concurrent psychiatric disorder that existed before the onset of alcohol abuse or that persists after a period of abstinence (usually 1 year) are considered to have a dual diagnosis. The prevalence of dual diagnosis, which occurs in up to 10% of patients who are alcohol dependent, may be greater among patients who also abuse other drugs.³⁵ Acute alcohol intoxication is often associated with violent behavior, and chronic alcohol abuse can result in memory impairment and a decreased intellectual function.

Clinical Assessment

A history of problems commonly associated with at-risk or problem drinking (Table 3) should prompt careful assessment of drinking behavior; likewise, at-risk and problem drinkers should be assessed for these problems.

Because alcohol-related problems are often dose-dependent, further information about the quantity and frequency of alcohol consumption may be helpful,

especially if family members confirm the patient's history. A family history of alcohol abuse is important information because there appears to be a genetic predisposition to alcoholism and because some individuals learn to drink abusively from family role models.

Laboratory Assessment

Laboratory testing should be guided by the clinical presentation. Because the liver is the organ most likely to be affected early in the course of alcohol abuse, an elevated serum gamma-glutamyltransferase (GGT) level may be an early diagnostic marker, even acutely. Because alcohol inhibits erythrocyte maturation, an elevated mean corpuscular volume (MCV) can be used as a marker for chronic excessive alcohol consumption.

PHYSICAL EXAMINATION AND ADDITIONAL PATIENT HISTORY

Physical examination reveals a pleasant, well-dressed, well-groomed woman with a height of 5'8", weight of 145 lb, temperature of 98°F, and blood pressure of 130/80 mm Hg. The examination is unremarkable.

After the physical examination, the physician assesses the patient for additional alcohol-related problems with a more detailed history. On further questioning, the patient admits to having blackouts (no memory of events while drinking), a depressed mood, and sleep disturbances. She has no abdominal complaints, admits to no sexual dysfunction, and denies any recent trauma. However, she does admit to driving while intoxicated and missing work on two or three occasions because of a hangover. She begins to cry again, and the physician touches her arm lightly to acknowledge her suffering, which seems to comfort the patient.

QUESTION

- **What factors are important to consider in deciding on a treatment approach?**

DISCUSSION

Assessing Patient Readiness for Treatment

Every patient is a candidate for a preventive health message, but the appropriate intervention for a particular patient depends on the patient's risk classification and willingness to change. The six-stage model of the change process in addictive behavior created by Prochaska et al³⁶ may be used to assess a patient's level of readiness and to tailor advice appropriately. The six stages include: 1) precontemplation, 2) contemplation, 3) determination, 4) action, 5) maintenance, and 6) relapse.

The model assumes that patients change their behavior gradually. At first, patients may not realize that

a change in behavior is necessary (Precontemplation). In the next stage, they recognize their problem and consider making a change (Contemplation). The next stage is deciding to make a change (Determination), although this decision may be accompanied by feelings of ambivalence. Finally, patients do something to change their behavior (Action), and then try to continue the new behavior (Maintenance). They may return to the old behavior (Relapse) despite their best efforts. Examples of appropriate advice according to phase of behavioral change are outlined in **Table 4**.

Risk Classification

A patient's level of health risk caused by drinking also determines what type of advice is appropriate for a given patient (**Table 5**). Patients who abstain from alcohol are not free of risk; these patients, particularly those who have had problems with alcohol in the past, should be encouraged to continue abstinence as the best way to prevent future problems. Patients who have relatives who are alcohol abusers should be informed about the genetic nature of alcoholism. Low-risk drinkers should be advised not to exceed low-risk levels and not to drink in risky situations. At-risk drinkers who exceed recommended low-risk levels should be advised to cut down on their drinking, and at-risk drinkers who have a strong family history of alcoholism can be advised to consider abstinence as the best way to prevent future alcohol-related problems. Problem drinkers should be advised to cut down or quit. Patient education materials are helpful in reinforcing the information that is given verbally by the physician.

Periods of abstinence are common early in the course of alcohol abuse among patients who still have the ability to control the onset of drinking even though the patients lack the ability to control the amount of drinking once they start. Some clinicians recommend "controlled drinking" as a test for early alcohol dependence. In controlled drinking, the patient is asked to drink a specific amount (one or two drinks each and every day) but no more and no less. Alcohol-dependent patients often find this test difficult and exceed the upper limit.

QUESTION

- **What treatment approaches are effective for at-risk and problem drinkers?**

DISCUSSION

Brief Intervention

A number of studies have demonstrated that at-risk and problem drinkers can benefit from a brief intervention, a short counseling session focused on helping

Table 4. Phases of Behavioral Change with Associated Patient Perspectives and Physician Tasks

Phase of Change	Patient Perspective	Physician Task
Precontemplation	Lacks awareness that behavioral change is necessary	To educate the patient about drinking, how alcohol is affecting the patient's health, and the need for a behavioral change (eg, provides verbal information, pamphlets, or other materials to the patient)
Contemplation	Considers or is ambivalent about behavioral change	To encourage the patient to make a decision to change a drinking pattern (eg, arranges for the patient to meet a recovering alcoholic or therapist or arranges a formal intervention)
Determination	Decides to make a behavioral change	To discuss the available options and action plan with the patient (eg, suggests a low-risk drinking goal, abstinence, professional treatment, or attendance at self-help groups)
Action	Takes action to make a behavioral change	To encourage the patient to follow through with the action plan despite anticipated barriers (eg, arranges for a reevaluation to monitor progress)
Maintenance	Maintains the new behavior	To reinforce the new behavior and to identify the patient who is at risk for relapse into the previous behavior
Relapse	Returns to the previous behavior	To educate the patient that relapses are common and to encourage the patient to take action to change the behavior (ie, return to the precontemplation phase)

Adapted with permission from Prochaska JO, DiClemente CC, Norcross JC: In search of how people change: applications to addictive behaviors. *Am Psychol* 1992;47:1102-1114.

Table 5. Advice for Patients According to Pattern of Drinking

Pattern of Drinking	Examples of Appropriate Advice
Abstinence	Reinforce the patient's choice of abstinence as the best way to avoid alcohol-related health problems
Low-risk drinking	Reinforce low-risk alcohol consumption recommendations as a good way to avoid alcohol-related health problems; advise patients not to drink in risky situations (eg, before driving or operating machinery)
At-risk drinking	Advise a reduction in alcohol consumption to low-risk levels and an avoidance of drinking in risky situations
Problem drinking	Advise a reduction in alcohol consumption to low-risk levels or a trial of abstinence; consider a referral to an alcohol abuse specialist for further assessment and treatment
Alcohol dependence	Advise a trial of abstinence; consider a referral to an alcohol abuse specialist for further assessment, detoxification, or treatment; if the patient is not ready to commit to a behavioral change, consider a formal intervention coordinated by a treatment specialist

Adapted from National Institute on Alcohol Abuse and Alcoholism: *The Physician's Guide to Helping Patients with Alcohol Problems*. Washington (DC): National Academy Press, 1995.

a person change specific behavior.^{23,37,38} Randomized controlled trials in primary care or community-based settings with at least 6 months of follow-up have demonstrated improved outcomes among problem drinkers who receive brief interventions compared to controls.³⁹⁻⁴² Specifically, these studies found that the groups receiving brief interventions reduced their alcohol consumption and had positive changes in health behaviors, reduced sick days, or both. Although the

type of intervention varied across trials, intervention usually included brief counseling sessions by physicians plus the provision of informative handouts on decreasing alcohol use for the patient to review after the visit.

Brief intervention methods vary but typically consist of three steps: 1) giving feedback (eg, expressing specific concerns about the patient's health); 2) providing patient-specific advice or recommendations; and 3) negotiating a specific plan of action. Most authorities

suggest using an empathic approach and a nonconfrontational style, conveying confidence in the patient's ability to change behavior and emphasizing the positive benefits of the change.⁸ A fundamental principle to remember is that positive reinforcement is more likely than disapprobation to produce a lasting behavioral change. Therefore, the negative consequences of continued behavior need not be given undue emphasis.

The statement of concern about the patient's drinking pattern and related health risks should be made in clear, concise, and unambiguous terms. For example, the physician might say, "Your alcohol use is damaging your liver." Advice, as mentioned earlier, should be based on the patient's risk category and readiness to change. Examples of advice include recommending that the patient abstain from alcohol or that the patient "cut down" on his or her drinking. If the patient does not agree to the recommended plan, a compromise should be sought. For example, if the physician recommends that the patient stop drinking and the patient refuses, the physician might propose a 2-week trial of abstinence and a follow-up visit.

BRIEF INTERVENTION IN THIS PATIENT

The physician says, "I am concerned about your drinking. Your behavior while you are drinking places your health and safety at risk. I would like you to stop using alcohol for a while or at least cut down." The patient is unwilling to try a period of abstinence but agrees to cut back to recommended low-risk drinking levels. She also promises not to drink before driving. A blood sample is obtained for complete blood count and determination of liver enzyme levels. A follow-up appointment is scheduled for 2 months later. Laboratory test results are notable for a normal MCV and a normal GGT.

QUESTION

- **How should patients with alcohol problems be monitored?**

DISCUSSION

Monitoring Patients with Alcohol Problems

The same clinical process of assessment, follow-up, and reassessment used to monitor any patient with a chronic medical condition can be used to monitor patients with alcohol-related problems. Patients may respond in different ways to physician advice, and progress is often made slowly through trial and error. Even the most skilled clinicians find that at least 50% of their patients turn a deaf ear at first. Behavioral change is difficult for any patient and tends to be an

incremental process. Progress, not perfection, is the goal.

Patients who are returning for reevaluation can be asked about the quantity and frequency of alcohol consumption, and any progress toward risk reduction made to date can be reinforced. Patients who abstain from alcohol or reduce drinking to below at-risk levels can be asked about progress in reducing the biomedical and psychosocial problems caused by alcohol abuse. Simple questions can be used to monitor this progress (eg, "How is your health?" "How are things going at home? At work?"). As progress is made, some patients come to face past behaviors and may experience shame, guilt, or depression. Although this experience is common and often resolves with time, selected patients may benefit from psychotherapy or treatment with antidepressant medications.

PATIENT PRESENTATION 1 YEAR LATER

The patient fails to keep her follow-up appointment but returns 1 year later for her annual gynecologic examination and for renewal of her birth control pills. She volunteers no specific health problems and her physical examination is unremarkable. Without prompting, the patient reports that she no longer drives after drinking but still drinks above low-risk levels and has become intoxicated on several occasions over the past year. She continues to experience blackouts and misses work occasionally after an evening of drinking.

QUESTION

- **What management approaches are useful in patients who do not adhere to the treatment plan?**

DISCUSSION

Management of Noncompliance

The patient who does not adhere to the negotiated plan of action often feels like a failure. The clinician can help the patient by continuing to use an emphatic, nonjudgmental style and by continuing to convey confidence that the patient can change. Additional options for behavioral change may be offered, but the physician should convey that such a change is ultimately the patient's responsibility.

Treatment options include referral to self-help groups (eg, Alcoholics Anonymous) or referral to formal alcohol treatment programs. Other options include a trial of abstinence, which may precipitate the signs and symptoms of withdrawal and provide evidence for the diagnosis of alcohol dependence. The primary care physician may wish to consider a referral

Table 6. The Twelve Steps of Alcoholics Anonymous

1. Admitted that we were powerless over alcohol—that our lives had become unmanageable
 2. Came to believe that a Power greater than ourselves could restore us to sanity
 3. Made a decision to turn our will and our lives over to the care of God as we understood Him
 4. Made a searching and fearless moral inventory of ourselves
 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs
 6. Were entirely ready to have God remove all of these defects of character
 7. Humbly asked Him to remove our shortcomings
 8. Made a list of all persons we had harmed, and became willing to make amends to them all
 9. Made direct amends to such people wherever possible, except when to do so would injure them or others
 10. Continued to take personal inventory and when we were wrong promptly admitted it
 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out
 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs
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to a chemical dependency consultant, social worker, psychologist, addictionologist, psychiatrist, or other professional with specific training and expertise in the field. The consultant can perform a more detailed assessment of the patient's problems and evaluate for substance abuse treatment. If the patient is severely affected and willing to accept treatment, sometimes the primary care physician can arrange for immediate treatment placement over the telephone while the patient waits in the examining room.

Alcoholics Anonymous

Physicians can encourage patients to participate in self-help groups such as Alcoholics Anonymous. AA is a fellowship of men and women who meet at regular intervals to share their "experience, strength, and hope" to assist each other in maintaining sobriety. The only requirement for membership is the desire to stop drinking. The precepts of AA are spiritual in nature, but the approach used does not contradict most religious beliefs and is compatible with nonreligious philosophies.

AA meetings may be either open or closed. The general public may attend open meetings, but only people who consider themselves "alcoholics" may attend closed meetings. People attending meetings agree to maintain the anonymity of AA members and not disclose the content of the meetings. Meetings generally last 1 hour and may be discussion-oriented or speaker-oriented. In discussion meetings, typically five to 30 people sit in a circle and address topics raised for discussion by individuals at the meeting. There is often a leader who serves only to maintain order during the discussion. In speaker-oriented meetings, individuals tell the stories of how their lives were while they were drinking, how they became sober, and how their lives have been since they became sober. In general, speakers' meetings tend to draw a large audience, sometimes a few hundred. Meetings may be targeted toward specific groups, such as women, lesbians and gay men, professionals, and nonsmokers.

Members of AA follow the "twelve steps," which they believe are essential for the process of recovery (**Table 6**). Some meetings are devoted to studying this twelve-step process. New members are expected to obtain a "sponsor," a member who generally has had at least 1 year of sobriety. The sponsor has regular telephone contact with the new member and helps the new member work through the twelve steps.

An abundance of AA conference-approved literature, available through the local AA chapter offices, has been developed. The book *Alcoholics Anonymous*,⁴³ also known as the "Big Book," describes the history of the organization and contains the personal stories of some of AA's original members. AA members are encouraged to use this book as a guide to recovery.

TREATMENT PLAN AND FOLLOW-UP

The physician tells the patient that he is concerned about the effects of her drinking and would like her to speak with somebody who can help her. However, the patient says that she wants to "deal with this alone." She agrees not to drink at all for 2 weeks and to call the office to speak with the physician after the 2-week period. This agreement is documented in her chart. She does not telephone as promised.

The patient does not return until the following year, reporting for her annual gynecologic examination and prescription renewal. When asked if she was able to abstain from alcohol, she reports that 3 months previously she stopped drinking following dental surgery. She experienced nausea, tremor, and a compulsion to drink, which led her to conclude that she was an "alcoholic." She cries as she recalls this event. She states that

she has often felt depressed, has missed workdays, and has experienced several blackouts over the past year. She also says that her husband returned from overseas about 6 months ago and that things were "not going well." Placing her hand on top of the physician's she tearfully asks, "What do I need to do?"

The physician encourages the patient to attend the meeting of a self-help group, but also offers to make a referral to an addictionologist or treatment center. After discussing her options with the physician, the patient agrees to attend an AA meeting. The physician calls AA while the patient is in the office and has her speak with an AA member, who identifies meetings held at convenient times and locations for the patient. She agrees to attend a meeting that night and to call the physician's office in 1 week to provide information on her progress.

One week later, the patient calls the physician's office and reports that she has not had a drink since the office visit and has obtained a sponsor in AA.

QUESTION

- **How may physicians assess the quality of a patient's recovery from alcohol problems?**

DISCUSSION

Recovery Assessment

Alcohol abuse is similar to other chronic diseases for which there is no cure. The process of recovering from problem drinking typically involves episodes of remission and relapse.⁴⁴ Some patients experience long-term remission with very few relapses, while others experience frequent and sometimes prolonged relapses. Recovery can be assessed by asking patients about their drinking habits, overall general health, psychological and social functioning, and what activities are being used to maintain recovery.

Patients who are in good recovery take care of their overall health, attend self-help meetings regularly, have a normal mood, maintain a positive attitude, are socially well-adjusted, and have good interpersonal relationships with their family and friends. They do not engage in compulsive or risky sexual behavior. They are able to function well at school or on the job and do not have unexplained "sick" days. Their finances are sound and they do not gamble compulsively. They do not experience recurrent legal problems and they obey the law. Some patients continue to experience psychological difficulty and may require ongoing psychotherapy to help resolve issues that occurred during their years of drinking. However, patients in good recovery usually remain optimistic that these issues can be resolved. A relapse

may be imminent if a patient is experiencing ongoing problems with any of these indicators. Frequently, a relapse is preceded by a change in attitude, a depressed mood, lack of adherence to attending self-help meetings or psychotherapy sessions, or problems with interpersonal relationships.

PATIENT PRESENTATION 1 YEAR LATER

One year later, the patient returns for her annual gynecologic examination and refill of her birth control pills. She reports that things are going well in her life. She is attending AA meetings three to four times a week, has a sponsor in AA, is reading AA literature regularly, and is following the twelve steps. She notes that she has been sober for 1 year. She no longer misses work and is happy in her job and her marriage.

CONCLUSION

This case illustrates how primary care physicians can encourage patients with alcohol problems to make incremental changes through brief and inexpensive office interventions. By providing early intervention, significant biomedical or psychosocial problems can be prevented. Without an intervention, the problems of the case patient would likely have progressed, and major health problems, divorce, or job loss may have followed. As the course of the disease progresses, patients may require expensive inpatient or outpatient treatment and long-term follow-up. When the disease is allowed to progress without treatment, patients may experience irreversible biomedical disease or death. By intervening early, primary care physicians can play an important part in decreasing the burden of disease caused by alcohol abuse. HP

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