

# Alcohol Dependence and Motivational Interviewing



# Assessment of Alcohol Misuse Checklist

- ✓ Establish rapport – patients are often resistant
- ✓ Longitudinal history of alcohol use
- ✓ Assess additional drug use
- ✓ Establish dependence based on ICD-10 (3 criteria required for diagnosis)
  - ✓ Strong compulsion to drink (craving)
  - ✓ Difficulty controlling the drinking
  - ✓ Withdrawal after cessation of drinking
  - ✓ Tolerance
  - ✓ Progressive neglect of alternative pursuits and interests
  - ✓ Persistence of drinking despite psychological and physical harm

# Assessment of Alcohol Misuse Checklist

- ✓ Impact on social, relationship and occupational functioning
- ✓ Assessment of depression and anxiety
- ✓ Risk assessment – physical health, self harm, suicide and violence

# DSM-IV Criteria for Alcohol Dependence

- Tolerance
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of alcohol
- Withdrawal syndrome or alcohol taken to relieve withdrawal symptoms
- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or there are unsuccessful efforts to cut down or control alcohol use.

# DSM-IV Criteria for Alcohol Dependence

- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its effects
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the alcohol

# Alcohol Misuse – DSM-IV

- Maladaptive pattern of alcohol abuse leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:
  - Recurrent alcohol use resulting in failure to fulfil major role obligations at work, school or home
  - Recurrent alcohol use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine)
  - Recurrent alcohol-related legal problems (e.g. arrests for alcohol-related disorderly conduct)
  - Continued alcohol use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about consequences of intoxication or physical fights)

# Guidelines for Safe Use of Alcohol

## Australian guidelines for safe use ([australia.gov.au](http://australia.gov.au))

- Drinking no more than two standard drinks on any day for men and women (standard drink = 10 g of alcohol)

## UK guidelines (Department of Health)

- NHS advice on drinking recommends that men should not regularly drink more than 3–4 units of alcohol/day and women should not regularly drink more than 2–3 units/day

# Diagnostic Interview for Alcohol Dependence

- Do you ever cope with your difficulties by having a drink / drinking / using drugs?
- How often do you drink?
- Over the last week: amount, type of alcohol
- Dependence features
- Do you feel you can control your drinking? (**lack of control**)
- Can you stop at one drink? (**lack of control**)
- Do you crave for a drink ? (**compulsion**)
- Have you found that your intake has gone up over the years? (**tolerance**)
- What's your longest period without a drink? (**abstinence management**)

# Diagnostic Interview for Alcohol Dependence

- Why did you stop? (implications for management- motivation)
- Do you ever get the shakes when you stop drinking? Have you ever had shakes or fits when you stopped drinking? (withdrawal symptoms)
- Do you find that drinking has become the most important thing in your life (neglect of alternate pursuits)
- Do you neglect other things and family for the drink (neglect of alternate pursuits)
- Ask for side effects – psychological, social, biological (hospitalizations, blackouts, memory problems, head injury, drink driving, relationships, employment (use despite physical and psychological harm)

## Supportive care

- Minimise stress by making sure area is bright, quiet, safe and private
- Psychoeducation and reassurance to the patient
- Coping skills – relaxation, sleep hygiene, mindfulness and methods to reduce craving

## Monitoring

- CIWA-AR, AWS (withdrawal scales) – severe withdrawal if AWS>15 and CIWA>20
- Temp, pulse, BP
- Level of Hydration-urine output
- Investigations-LFT, GGT, urea and electrolytes, FBC, CRP and Chest X-Ray

## Treatment

- Diazepam sliding scale or another long acting benzodiazepine sliding scale (e.g. chlordiazepoxide) according to local use
- Oral/I.V fluids to prevent rehydration
- Prevent Wernicke's encephalopathy: IM/IV High potency vitamins (pabrinex) recommended by Maudsley guidelines for 3-5 days
- Use short acting Benzodiazepines like Oxazepam or Lorazepam if patient has liver disease

# Delirium Tremens

- Medical emergency – mortality of 5%
- Usually occurs in 3-7 days after last drink
- Clinical symptoms
  - Clouding of consciousness and confusion
  - Vivid hallucinations in all modalities
  - Tremor
  - Autonomic instability
  - Seizures
  - Hyperthermia

- Treatment
  - Continuous nursing care in a intensive care unit with IV fluids and monitoring of vitals
  - Effective sedation with IV benzodiazepines
  - IV Thiamine (100 mg) to prevent or treat Wernicke's encephalopathy
  - Potassium and magnesium supplements

## Disulfiram (APT, 2006)

- 800 mg first dose, reduce to 100-200mg/day
- Acetaldehyde dehydrogenase inhibitor
- 2 trials showed reduction in number of drinking days but largely efficacy is unproven
- Can cause fatal hepatotoxicity

## Naltrexone (APT, 2006)

- Opioid receptor antagonist
- Reduces craving for alcohol
- Does not interact with alcohol
- Meta-analyses confirm it is as effective as Acamprosate

## Acamprosate

- Analogue of GABA
- Effective in relapse prevention, doubling the chances of achieving continuous abstinence following detox (Sass, 1996)

# Psychosocial Treatments in Alcohol Dependence

- Alcoholics anonymous
- Motivational enhancement therapy (Miller and Rollnick)
- Cognitive Behavioural therapy (Marlatt and Gordon)
- Social skills training
- Social behaviour and network therapy (UKATT study)
- Contingency management
- Cue exposure
- Therapeutic communities and residential rehabilitation

# Evidence Based Psychosocial Treatments for Alcohol Dependence

- Inpatient detoxification required for special indications
- Brief interventions: short focussed discussions (<15min) can reduce alcohol consumption in some adults (Project TrEAT) (Fleming, 1997)
- UKATT (United Kingdom Alcohol Treatment Trial)
  - Multicentre trial in UK
  - 742 participants randomised to social behaviour and network therapy or to motivational enhancement therapy
  - Follow up at 3 and 12 months
  - Results: both groups showed similar substantial reductions

# Evidence Based Psychosocial Treatments for Alcohol Dependence

Home and inpatient detoxification have no difference in outcome (Edwards & Guthrie, 1967)

Project MATCH (Matching Alcohol Treatments to Client Heterogeneity) multicentre US trial

- 2 groups: inpatient and outpatient
- 3 forms of manualised psychotherapy
- 4 sessions of Motivational Enhancement Therapy, 12 steps of twelve step facilitation or 12 sessions of CBT
- Follow up at 1 and 3 years
- Results: no significant difference between 3 modalities
- In-patient clients were more abstinent than out patients

# Motivational Enhancement Therapy

- Developed by Miller and Rollnick (2000)
- Based on theories of cognitive dissonance
- Takes individual along the Prochaska and Di Clemente cycle of change
- FRAMES principle
  - F – Provide Feedback on behaviour
  - R – Reinforce patient’s Responsibility for changing behaviour
  - A – State Advice about changing behaviour
  - M – Discuss Menu of options to change behaviour
  - E – Express Empathy for the patient
  - S – Support patient’s Self-efficacy

# Questions in Motivational Interviewing

## Precontemplation phase

- Do you think your alcohol use is of concern?

## Contemplation phase

- What concerns you about your drug and alcohol use?

## Intention to change phase

- The fact that you are here indicates that at least part of you thinks it is time to do something
- What would be the advantages of making a change?

## Maintenance

- What encourages you that you can change if you want to?
- What are some of the practical things you would need to achieve this goal?

# Questions in Motivational Interviewing

## Affirmation

- I appreciate you took a big step in coming here today

## Enhancing cognitive dissonance

- Can you tell me what are the good things about drinking for you?
- Can you tell me some of the less good things about your alcohol use? (avoid words such as problem)
- Now that you have told me the good things and less good things, what thoughts do you have?

# Cognitive Behavioural Therapy

- Based on work of Marlatt and Gordon
- Based on assumption that alcoholism is a maladaptive habit adapted as a coping mechanism
- Involves:
  - Relapse prevention
  - Behavioural marital therapy
  - Social skills training
  - Community reinforcement techniques