Management of Alcohol Dependence Syndrome

Outline

1. DEPENDENCE, CTRITERIA, TYPOLOGY
2. ASSESMENT
3. INTERVENTIONS
4. DETOXIFICATION
5. RELAPSE PREVENTION
6. DRUGS
7. COMPLICATIONS
8. NON PHARMACOLOGICAL METHODS

Dependence

"A CLUSTER OF PHYSIOLOGICAL, BEHAVIORAL AND COGNITIVE PHENOMENA IN WHICH USE OF A SUBSTANCE OR A CLASS OF SUBSTANCES TAKES ON A MUCH HIGHER PRIORITY FOR A GIVEN INDIVIDUAL THAN OTHER BEHAVIORS THAT ONCE HAD GREATER VALUE"

Dependence Criteria [ICD-10]

1. COMPULSION TO TAKE SUBSTANCE
2. IMPAIRED CONTROL OF SUBSTANCE-TAKING BEHAVIOR
3. PHYSIOLOGICAL WITHDRAWAL STATE
4. TOLERANCE TO EFFECTS OF SUBSTANCE
5. PREOCCUPATION WITH SUBSTANCE USE
6. PERSISTENT USE DESPITE HARMFUL CONSEQUENCES

Typology

TYPE 1 (75%)	TYPE 2
Environment predisposition [Only males]	Male limited-Genetic predisposed(sons of male alcohol dependent persons v common, but females as well)
Age of onset >26 years	Age of onset <=25 years
High harm avoidance	Low harm avoidance
Low novelty seeking	High novelty seeking

Assessment of Dependence

- USE, PATTERN , DAILY CONSUMPTION
- PREVIOUS WITHDRAWAL EPISODES
- LAST DOSE
- SEVERITY OF DEPENDENCE AND WITHDRAWAL
- CO-MORBIDITIES
- COGNITIVE TESTING
- PHYSICAL EXAMINATION
- BREATHALYZER
- INVESTIGATIONS- LFTS, INR, PT AND URINARY DRUG SCREEN
- STRUCTURED TOOLS- AUDIT, SADQ

Biomarkers

Parameter	**Normal value**	**Value in chronic alcoholics**
Mean corpuscular volume or mean cellular volume,	80-98µm3	>100 μm^3
AST & ALT	<45 U/L	AST:ALT, 2:1
Serum level of γ-glutamyl transferase	Men 4-25 U/L Women 7-40 U/L	>30 U/L
Serum level of uric acid	024 051µmol/L	>.6 µmol/L
Carbohydrate-deficient transferrin	<60mg/l	>1.3% of total transferrin concentration
Megaloblastic anemia, Low platelet count,		

IMPAIRMENTS AT DIFFERENT BAC'S

20-30 mg/dL	Slowed motor performance ,decreased thinking ability
30-80 mg/dL	Increases in motor,cognitive problems
80-200 mg/dL	Increases in incoordination, judgement errors Mood lability Deterioration in cognition
200-300 mg/dL	Nystagmus,marked slurring of speech,alcoholic blackouts
>300 mg/dL	Impaired vital signs,possible death

Domains and Item Content of the AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence Symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful Alcohol Use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

Management

THREE STEPS

1. INTERVENTION
2. DETOXIFICATION
3. REHABILITATION (INCLUDES RELAPSE PREVENTION)

Intervention

- INTERVENTION IS A PROCESS AIMED AT INCREASING MOTIVATION TO AS HIGH A LEVEL AS POSSIBLE REGARDING TREATMENT AND CONTINUED ABSTINENCE.
- BRIEF INTERVENTIONS ARE TYPICALLY OF **5- 30 MINUTES** DURATION.
- INVOLVE **MOTIVATIONAL INTERVIEWING AND COUNSELLING TECHNIQUES.**
- USUALLY TARGETED AT INDIVIDUALS WHO ARE **RISKY** RATHER THAN DEPENDENT DRINKERS.
- THE AIM IS TO **ALERT THE DRINKER THAT THEY ARE DRINKING AT LEVELS THAT COULD LEAD TO HEALTH PROBLEMS, AND ENCOURAGE THEM TO REDUCE THEIR CONSUMPTION** TO REDUCE THE RISK OF FUTURE HEALTH PROBLEMS.

FRAMES

FEEDBACK: PERSONAL **FEEDBACK** ABOUT THE RISKS ASSOCIATED WITH CONTINUED DRINKING, BASED ON CURRENT DRINKING PATTERNS, PROBLEM INDICATORS, AND HEALTH STATUS.

RESPONSIBILITY: EMPHASIS ON THE INDIVIDUAL'S PERSONAL **RESPONSIBILITY** AND CHOICE TO REDUCE DRINKING BEHAVIOR.

ADVICE: CLEAR **ADVICE** ABOUT THE IMPORTANCE OF CHANGING CURRENT DRINKING PATTERNS

FRAMES

MENU A **MENU** OF ALTERNATIVE CHANGE OPTIONS. THIS EMPHASIZES THE INDIVIDUAL'S CHOICE TO REDUCE DRINKING PATTERNS AND ALLOWS THEM TO CHOOSE THE APPROACH BEST SUITED TO THEIR OWN SITUATION.

EMPATHY: FROM THE PERSON PROVIDING THE INTERVENTION IS AN IMPORTANT DETERMINANT OF PATIENT MOTIVATION AND CHANGE.

SELF-EFFICACY: INVOLVES INSTILLING OPTIMISM IN THE PATIENT THAT HIS OR HER CHOSEN GOALS CAN BE ACHIEVED.

Detoxification

- **SOBERING UP ACUTELY INTOXICATED** PATIENTS TO MANAGEMENT OF SEVERE WITHDRAWAL SYMPTOMS
- PREVENTS MARCH OF EARLY WITHDRAWAL SYMPTOMS TO LIFE THREATENING COMPLICATIONS
- **RELIEVE WITHDRAWAL SYMPTOMS**
- OPPORTUNITY TO EXPLORE, ASSESS, INITIATE MODIFICATION OF MEDICAL, SOCIAL, PSYCHIATRIC AND LIFE STYLE PROBLEMS.

Detoxification

GOALS OF DETOXIFICATION

- TREATMENT OF ALCOHOL WITHDRAWAL SYMPTOMS
- PREVENTION OF INITIAL AND RECURRENT SEIZURES
- PREVENTION AND TREATMENT OF DELIRIUM TREMENS
- PREVENTION OF MEDICAL AND PSYCHIATRIC COMPLICATIONS OF ALCOHOL WITHDRAWAL
- PREVENTION OF WERNICKE-KORSAKOFF'S PSYCHOSIS
- IMPROVEMENT IN LIKELIHOOD OF ABSTINENCE

Withdrawal Symptoms

- SOMATIC SYMPTOMS

1. TREMOR OF THE OUTSTRETCHED HANDS, TONGUE OR EYELIDS;
2. SWEATING;
3. NAUSEA, RETCHING OR VOMITING;
4. TACHYCARDIA OR HYPERTENSION;
5. PSYCHOMOTOR AGITATION;
6. HEADACHE;
7. INSOMNIA;
8. MALAISE OR WEAKNESS;

Withdrawal Symptoms

- SEIZURES
- HALLUCINATIONS
- DELIRIUM TREMENS
- PROTRACTED WITHDRAWAL : ANXIETY, INSOMNIA, AND MILD AUTONOMIC OVER ACTIVITY TO CONTINUE FOR 2 TO 6 MONTHS

MANIFESTATION	ONSET	INFORMATION
Somatic symptoms	3-12 hours	Peak at 24-48 hrs Last for 5-14 days
Seizures	12-18 hours	Benzodiazepine cover
Delirium Tremens	3-4 days	Devleop in 5% Mortality 10-20 %

Clinical Institute Withdrawal Assessment for Alcohol scale, revised (CIWA-Ar),

- NAUSEA AND VOMITING 0-7
- TREMOR 0-7
- PAROXYSMAL SWEATS 0-7
- ANXIETY 0-7
- AGITATION 0-7
- TACTILE DISTURBANCES 0-7
- AUDITORY DISTURBANCES 0-7
- VISUAL DISTURBANCES 0-7
- HEADACHE OR FULLNESS OF HEAD 0-7
- CLOUDING OF CONSCIOUSNESS 0-4

- MAXIMUM SCORE 67,
- <10 NO REQUIREMENT OF ADMISSION
- 10-15 ADMIT FOR OBSERVATION
- >15 TREATMENT SHOULD BE STARTED

Pharmacologically assisted withdrawal

PHARMACOLOGICALLY ASSISTED WITHDRAWAL IS LIKELY TO BE NEEDED WHEN:

- REGULAR CONSUMPTION OF >15 UNITS/DAY
- AUDIT SCORE >20

SYMPTOM SCALES

- THE CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED > 15
- SHORT ALCOHOL WITHDRAWAL SCALE > 12

ASSISTED WITHDRAWAL REGIMENS SHOULD NEVER BE STARTED IF THE BLOOD ALCOHOL CONCENTRATION IS VERY HIGH OR IS STILL RISING

WITHDRAWAL 1. COMMUNITY BASED

2. IN-PATIENT BASED

COMMUNITY BASED:

1. CARE-GIVER SUPPORT
2. TREATMENT AND CONTINGENCY PLANS
3. ALTERNATE DAY FOLLOW UP
4. PSYCHOSOCIAL SUPPORT

IN-PATIENT INDICATIONS:

- REGULAR CONSUMPTION OF >30 UNITS/DAY.
- SADQ >30
- HISTORY OF SEIZURES OR DT.
- VERY YOUNG OR ELDERLY.
- CURRENT BENZODIAZEPINE USE
- OTHER SUBSTANCE MISUSE OR ABUSE
- CO-MORBID MENTAL OR PHYSICAL ILLNESS, LEARNING DISABILITY OR COGNITIVE IMPAIRMENT.
- PREGNANT.
- NO SOCIAL SUPPORT.
- HISTORY OF FAILED COMMUNITY DETOXIFICATION(S).

BZD’s

BENZODIAZEPINES ARE THE TREATMENT OF CHOICE FOR ALCOHOL WITHDRAWAL.

MECHANISM OF ACTION-

1. CROSS-TOLERANCE
2. ANTI-CONVULSANT PROPERTIES

- CHLORDIAZEPOXIDE COMMONLY USED- LOW DEPENDENCE FORMING POTENTIAL
- HEPATIC IMPAIRMENT- SHORT-ACTING BENZODIAZEPINE TREATMENT OF CHOICE.

Drug	Half Life	Initial Dose	Average Dose/ Day	Maximum Dose/Day
Chlordiaze-poxide	24-48 hours	25mg	50-100mg	250mg
Diazepam	20-90 hours	5mg	10-20mg	100mg
Lorazepam	10-20 hours	1mg	2-4mg	12mg
Oxazepam	4-14 hours	15mg	10-30mg	200mg

Withdrawal Regimens

1. FIXED DOSE REDUCTION
2. VARIABLE DOSE REDUCTION
3. FRONT LOADING

Fixed Dose Regimens

- COMMUNITY OR NON-SPECIALIST INPATIENT/ RESIDENTIAL SETTINGS.
- STARTING DOSE OF CHLORDIAZEPOXIDE CAN BE ESTIMATED FROM CURRENT ALCOHOL CONSUMPTION. (20 UNITS- 20MG QID)
- TAPER OVER 5-7 DAYS
- MONITOR ON CIWA-AR OR SAWS

Example of a FDR in moderate dependence

Time	Dose	Total daily dose
Day 1	20 mg qds	80 mg
Day 2	15 mg qds	60 mg
Day 3	10 mg qds	40 mg
Day 4	5 mg qds	20 mg
Day 5	5 mg bd	10 mg

Example of FDR in severe dependence

Time	Dose	Total daily dose (mg)
Day 1	40 mg qds + 40 mg prn	200
Day 2	40 mg qds	160
Day 3	30 mg qds	120
Day 4	25 mg qds	100
Day 5	20 mg qds	80
Day 6	15 mg qds	60
Day 7	10 mg qds	40
Day 8	10 mg qds	30
Day 9	5 mg qds	20
Day 10	10 mg nocte	10

Variable Dose Reduction

- SPECIALIST ALCOHOL INPATIENT OR RESIDENTIAL SETTINGS.
- IN PATIENTS WITHOUT HISTORY OF COMPLICATIONS

- REGULAR MONITORING AND SEVERITY ASSESSMENT-MEDICATION ONLY WHEN WITHDRAWAL SYMPTOMS
- CHLORDIAZEPOXIDE 20–30 MG HOURLY AS NEEDED
- 24-48 HOURS BEFORE SWITCHING TO INDIVIDUALIZED FIXED DOSE REDUCTIONS

Front Loading Regimen

- INITIAL LOADING DOSE OF MEDICATION, E.G. CHLORDIAZEPOXIDE 100 MG, FOLLOWED BY FURTHER DOSES OF BETWEEN 50 AND 100 MG APPROXIMATELY EVERY 4–6 HOURS UNTIL LIGHT SEDATION IS ACHIEVED.
- MONITORED EVERY 2 HOURS :BASIC OBSERVATIONS AND A WITHDRAWAL SCALE.
- C/I IN ADVANCED LIVER DISEASE, COPD OR FOLLOWING A HEAD INJURY.
- USE IN WELL-MONITORED INPATIENT SETTINGS.

- CIWA-AR SCORE >15 OR A SAWS SCORE >12 DURING ASSISTED WITHDRAWAL- FURTHER INTERVENTION IS REQUIRED
- IN HALLUCINATIONS OR AGITATION, AN INCREASED DOSE OF BENZODIAZEPINE SHOULD BE ADMINISTERED
- **LIVER CIRRHOSIS AND/OR FUNCTIONAL LIVER IMPAIRMENT,** CHRONIC RESPIRATORY DISEASE – OXAZEPAM PREFERRED
- WITHDRAWAL SCALE SHOULD BE USED AS A MARKER OF OPTIMAL DOSING

Treating Somatic Symptoms

1. **DEHYDRATION** ADEQUATE FLUID INTAKE.
2. **PAIN** PARACETAMOL
3. **NAUSEA AND VOMITING** METOCLOPRAMIDE 10 MG OR PROCHLORPERAZINE 5 MG 4–6 HOURLY
4. **DIARRHOEA** DIPHENOXYLATE AND ATROPINE OR LOPERAMIDE
5. **SKIN ITCHING** ANTIHISTAMINES

Other Drugs

SUPPLEMENTARY VITAMINS

- INPATIENT DETOXIFICATION: PARENTERAL THIAMINE –PROPHYLAXIS AGAINST WERNICKE'S ENCEPHALOPATHY
- IM/IV AMPULES B-COMPLEX VITAMINS FOR 3-5 DAYS
- OUTPATIENT BASIS – ORAL THIAMINE 300 MG MINIMUM DAILY
- IM PREPARATIONS LESS ANAPHYLACTIC

OTHER PSYCHOTROPICS

DO NOT TREAT WITH PSYCHOTROPICS UNTIL PATIENT HAS BEEN ASSESSED WHEN ABSTINENT FROM ALCOHOL..

Complications

1. DELIRIUM TREMENS :A TOXIC CONFUSIONAL STATE

- THE CLASSIC TRIAD :

1. CLOUDING OF CONSCIOUSNESS/CONFUSION
2. VIVID HALLUCINATIONS AFFECTING EVERY SENSORY MODALITY
3. MARKED TREMOR.

- OCCURS IN 5% PATIENTS
- REPORTED MORTALITY- 5-10 %

Risk Factors

1. CONCOMITANT MEDICAL/SURGICAL ILLNESS
2. OLDER AGE
3. PRIOR DT
4. PRIOR DETOXIFICATION
5. PRIOR SEIZURES
6. TIME SINCE LAST DRINK
7. MALNUTRITION
8. SEVERITY OF ALCOHOL DEPENDENCE
9. ELEVATED SGOT
10. INCREASED CRAVING
11. HIGHER BAC
12. LONG DURATION OF ALCOHOL DEPENDENCE >6 YEARS

Clinical Features

1.PARANOID DELUSIONS

2.AGITATION

3.SLEEPLESSNESS AND

4.AUTONOMIC HYPERACTIVITY (TACHYCARDIA, HYPERTENSION, SWEATING AND FEVER).

SYMPTOMS OF DT TYPICALLY

PEAK BETWEEN 72–96 HOURS AFTER THE LAST DRINK.

Treatment

- EARLY DIAGNOSIS
- PROMPT TRANSFER TO MEDICAL SETTING
- CHECK FOR CONCOMITANT MEDICAL PROBLEM AND IMMEDIATE TREATMENT
- INTRAVENOUS DIAZEPAM OR LOREZEPAM IF HEPATIC IMPAIRMENT PRESENT
- PARENTERAL THIAMINE AND MULTIVITAMINS
- FLUID AND ELECTROLYTE REPLACEMENT

Seizures

- SEIZURE FOR THE FIRST TIME DURING ASSISTED WITHDRAWAL -INVESTIGATE TO RULE OUT ORGANIC DISEASE OR IDIOPATHIC EPILEPSY.

- LONGER-ACTING BENZODIAZEPINES - MEDICALLY ASSISTED WITHDRAWAL IN THOSE WITH A PREVIOUS HISTORY OF SEIZURES

Seizures

CARBAMAZEPINE LOADING CONSIDERED IN PATIENTS

1. UNTREATED EPILEPSY

2. HISTORY OF MORE THAN TWO SEIZURES DURING PREVIOUS WITHDRAWAL EPISODES

3. PREVIOUS SEIZURES DESPITE ADEQUATE BENZODIAZEPINE LOADING

NO NEED TO CONTINUE AN ANTICONVULSANT LONG-TERM

Hallucinations

- HALLUCINATIONS - INCREASE THE BDZ DOSE.
- ADDITION OF AN ANTIPSYCHOTIC (E.G. HALOPERIDOL 5–10MG ORALLY UP TO TDS) SHOULD BE CONSIDERED IF BZD FAILS BUT CAUTIOUSLY DUE TO RISK OF SEIZURES

Wernicke’s Enchephalopathy

- WERNICKE’S ENCEPHALOPATHY IS A PROGRESSIVE NEUROLOGICAL CONDITION CAUSED BY THIAMINE DEFICIENCY.

- OPHTHALMOPLEGIA, ATAXIA AND CONFUSION

- TREATMENT:
- 2 PAIRS OF PABRINEX IVHP (I.E. 4 AMPOULES) TDS FOR 3–5 DAYS
- ONE PAIR OF AMPOULES ONCE DAILY FOR A FURTHER 3–5 DAYS OR LONGER

Protracted Withdrawal

- SYMPTOMS OF ANXIETY, INSOMNIA, AND MILD AUTONOMIC OVERACTIVITY - 2 TO 6 MONTHS AFTER THE ACUTE WITHDRAWAL
- NO PHARMACOLOGICAL TREATMENT FOR THIS SYNDROME APPEARS APPROPRIATE.
- IT IS POSSIBLE THAT **ACAMPROSATE** MAY WORK.

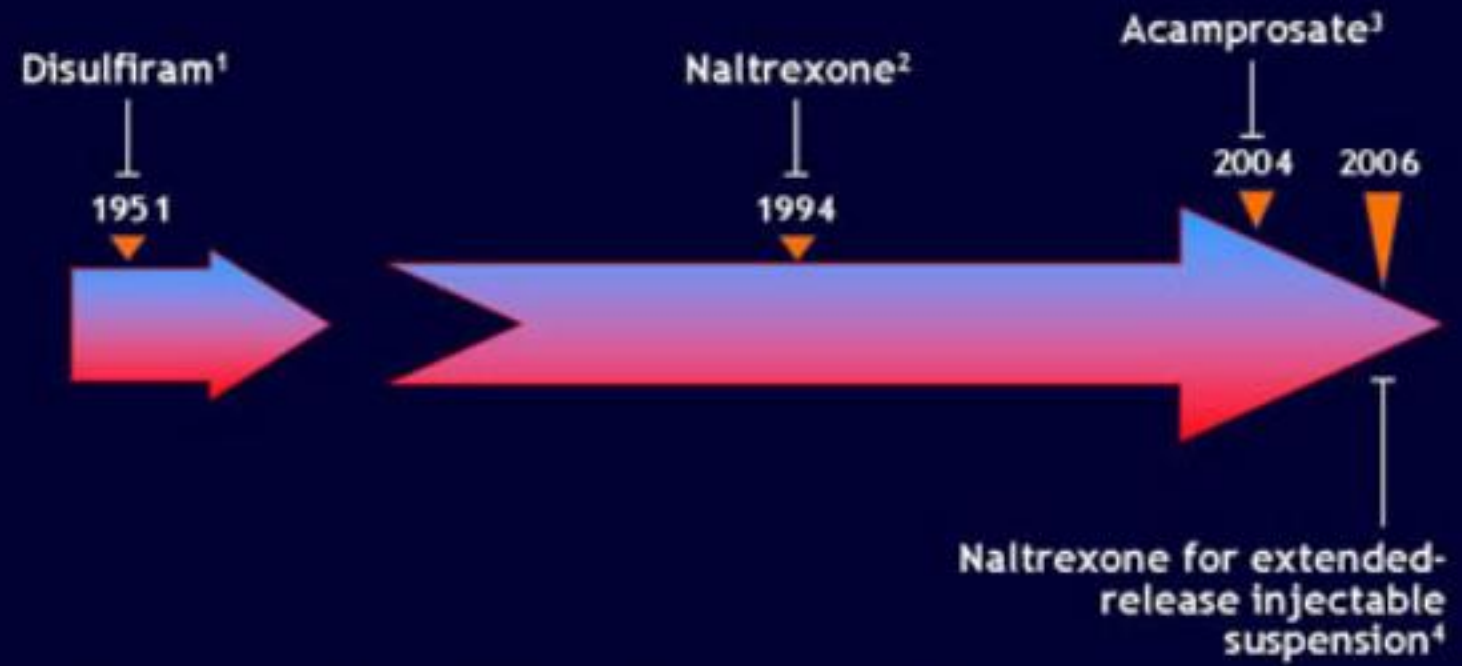
Relapse Prevention

PHARMACOLOGICAL MEASURES

FDA APPROVED DRUGS

1. ACAMPROSATE
2. DISULFIRAM
3. NALTREXONE
4. LONG ACTING NALTREXONE INJECTIBLE

FDA-approved Pharmacological Treatments for Alcohol Dependence



1. Antabuse [package insert]. East Hanover, NJ: Odyssey Pharmaceuticals; 2001.
2. ReVia [package insert]. Pomona, NY: Duramed Pharmaceuticals, Inc.; 2005.
3. Campral [package insert] St. Louis, MO: Forest Pharmaceuticals; 2005.
4. Vivitrol [package insert]. Cambridge, MA: Alkermes, Inc.; 2006.

OTHER DRUGS:

1.TOPIRAMATE

2.GABAPENTIN AND PREGABALIN

3.SSRI

4.ONDASETRON

5.BACLOFEN

6.NALMEFENE

PHARMACOLOGICAL MEASURES SHOULD ALWAYS BE USED IN CONJUNCTION WITH PSYCHOSOCIAL INTERVENTTIONS

ACAMPROSATE

- TAURINE ANALOGUE.
- FUNCTIONAL GLUTAMATERGIC NMDA ANTAGONIST.
- DOSE - IN ADULTS ABOVE 60KG, 1998MG [666MG TDS] DURATION 6MONTHS TO 1 YEAR
- C/I - RENAL IMPAIRMENT, SEVERE HEPATIC IMPAIRMENT, PREGNANCY/LACTATION
- A/E - GI DISCOMFORT, PARAESTHESIA, RASH, CHANGES IN LIBIDO, CONFUSION, DIARRHEA, NAUSEA,
- TREATMENT SHOULD BE STOPPED IN PERSONS WHO CONTINUE TO DRINJ 4-6 WEEKS AFTER STARTING DRUGS

NALTREXONE

- OPIOID ANTAGONIST
- MECHANISM OF ACTION- DECREASES DOPAMINE RELEASE DUE TO ALCOHOL INHIBITING REWARD SYSTEM
- DOSE- 50MG DAILY
- RECENT STUDIES- 100 MG DAILY
- START WHEN DRINKING OR DURING ASSISSTED WITHDRAWAL, CONTINUE TILL 6 MNTHS OR MORE
- S/E – NAUSEA, HEADACHE, ABDOMINAL PAIN, REDUCED APPETITE
- C/I CURRENT OPIOID USAGE/ HEPATIC FAILURE

NALMEFENE

- OPIOD ANTAGONIST
- REDUCES HEAVY DRINKING
- DOESN’T PROMOTE ABSTINENCE
- 20/ DAY DOSE COMMONLY USED
- APPROVED BY EUROPEAN MEDICINES AGENCY

SSRI

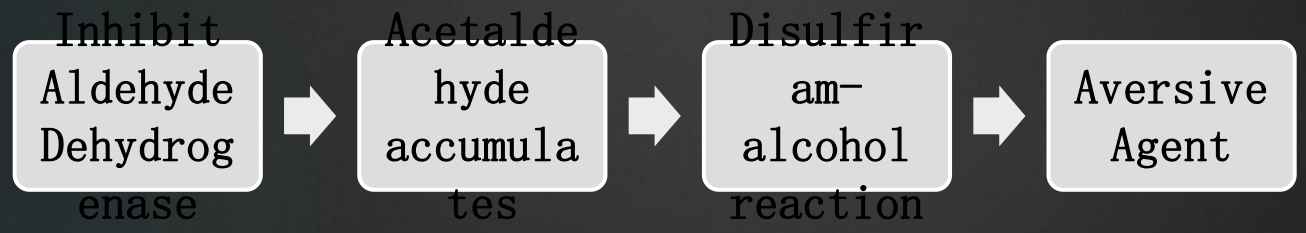
- DECREASED SEROTONIN- INCREASED IMPULSIVITY
- STUDIES LIMITED AND INCONSISTENT
- FLUXETINE 60 MG REDUCED AVERAGE DAILY CONSUMPTION
- SIGNIFICANT IMPROVEMENT IN PT'S WITH CO-MORBID DEPRESSION

BACLOFEN

- GABA B AGONIST.
- DECREASES DOPAMINERGIC ACTIVITY IN ‘REWARD PATHWAY’
- ADDOLORATO ET AL. SHOWED INCREASED ABSTINENCE RATES WITH NO ADVERSE EFFECTS
- REDUCES ANXIETY IN SEVERE DEPENDENCE
- DOSAGE : 10-20 MG TDS

DISULFIRAM (AVERSIVE AGENT)

FIRST DRUG TO BE APPROVED BY FDA



DISULFIRAM ALCOHOL REACTION

- HEADACHE
- FLUSHING
- BLURRED VISION
- GIDDINESS
- NAUSEA AND VOMITING
- HYPOTENSION
- THIRST

COMPLICATIONS

- OPTIC NEURITIS
- PERIPHERAL NEUROPATHY
- FATAL HEPATITIS
- CARDIOVASCULAR COLLAPSE
- ARRHYTHMIAS

Disulfiram Ethanol Reaction T/T

- SUPPLEMENTAL O2 ADMINISTRATION, IV ACCESS STARTED
- THIAMINE+GLUCOSE+NALOXONE IV IF ALTERED MENTAL STATUS
- INTUBATION IF PT IS COMATOSE
- IV FLUIDS TO REPLACE VOLUME LOSS. PHENOTHIAZINE IF INTRACTABLE VOMITING.
- VASOPRESSORS IF PT IS IN SHOCK
- GASTRIC EMPTYING NOT VERY EFFECTIVE UNLESS LARGE ETHANOL CONSUMPTION SUSPECTED

COMORBIDITIES

- ALD- ACAMPROSATE IF CHILD-PUGH C
  - BACLOFEN CAN BE CONSIDERED
- DEPRESSION- SSRI (SERTRALINE)+ NALTREXONE
- BPAD- NALTREXONE > ACAMPROSATE > DISULFIRAM, AVOID LITHIUM
- ANXIETY – BZD WITH CAUTION, BACLOFEN AND ACAMPROSATE CONSIDERED

COMORBIDITIES

- ADS+ COCAINE DEPENDENCE- NALTREXONE
- ADS+ BZD DEPENDENCE- SINGLE BZD
- ADS+ ODS- NALTREXONE

Non - Pharmacological Relapse Prevention

- MOTIVATIONAL ENHANCEMENT
- SOCIAL SKILLS TRAINING
- COGNITIVE BEHAVIORAL APPROACHES
- BEHAVIORAL MARITAL THERAPY

Abstinence v/s Controlled drinking

- AMONG PTS ATTENDING SPECIALIZED CLINICS THE PROPORTION WHO CAN **SUSTAIN PROBLEM FREE DRINKING IS SMALL- 5%**
- ABSTINENCE IS BETTER
- NO SAFE DRINKING LIMITS
- RCT DOESN’T FAVOR CONTROLLED DRINKING

Maintaining Motivation

ENHANCING MOTIVATION HAS A PLACE NOT ONLY AT ONSET BUT THROUGHOUT THE CLINICAL CONTACT

RCT: MOTIVATION ENHANCEMENT>TRADITIONAL SUPPORTIVE THERAPY

PTS COERCED INTO TREATMENT HAVE MEDIUM-TERM OUTCOMES SIMILAR TO THOSE WHO ATTEND VOLUNTARILY.

REDUCE THE CLIENT' S FEAR AND DISTRUST OF TREATMENT
PROGRAMS AND THEREBY ENCOURAGE THE CLIENT TO CONTINUE ATTENDING TREATMENT AND FOLLOW-UP APPOINTMENTS

Maintaining Motivation

- IT IS NOT EXPECTED THAT COUNSELLING ALONE IS SUFFICIENT TO CHANGE THE DRINKING BEHAVIOR OF MOST CLIENTS.
- RATHER, THE GOAL OF COUNSELLING IS TO DEVELOP A RELATIONSHIP BETWEEN THE CLINICIAN AND THE CLIENT, WHICH SUPPORTS **IMPLEMENTING SPECIFIC STRATEGIES** DESIGNED TO COMBAT THE DRINKING PROBLEM.

AA

- ALCOHOLISM IS VIEWED BY AA AS A PHYSICAL, PSYCHOLOGICAL & SPIRITUAL ILLNESS WHICH CAN BE ARRESTED BUT NOT CURED.
- 12 STEPS
- THE USE OF PRESCRIBED MEDICATION IS NOT FORMALLY DISAPPROVED OF BY AA.
- ITS IS ONLY AN ADJUNCT TO FORMAL TREATMENT.
- AA CAN HAVE AN INCREMENTAL EFFECT WHEN COMBINED WITH FORMAL TREATMENT, AND AA ATTENDANCE ALONE MAY BE BETTER THAN NO INTERVENTION.
- SLIGHTLY BETTER OUTCOMES AFTER 1 & 3 YEARS COMPARED TO CBT, MET

Cognitive behavioural interventions

COGNITIVE BEHAVIORAL INTERVENTIONS ENCOMPASS A RANGE OF STRATEGIES AND TECHNIQUES INCLUDING

- SKILLS TRAINING,
- BEHAVIORAL SELF-MANAGEMENT,
- COGNITIVE RESTRUCTURING,
- CUE EXPOSURE AND
- BEHAVIORAL COUPLES THERAPY
- COGNITIVE BEHAVIORAL INTERVENTIONS AIM TO GIVE THE CLIENT A SET OF THINKING AND BEHAVING STRATEGIES THAT CAN BE USED TO CHANGE PROBLEMATIC BEHAVIORS

Skills training

- IT INVOLVES **TEACHING PEOPLE SOCIAL SKILLS** THAT MIGHT HELP THEM FUNCTION WITHOUT THE USE OF ALCOHOL.

- THERE IS CONSISTENT EVIDENCE THAT SKILLS TRAINING HELPS TO **REDUCE ALCOHOL CONSUMPTION IN BOTH THE SHORT TERM AND THE LONG** TERM AMONG RISKY DRINKERS AND ALCOHOL DEPENDENT PERSONS.

- EMPHASIS IS PLACED ON ENSURING THAT CLIENTS LEARN TO AND LISTEN TO COMMUNICATE EFFECTIVELY, GIVE AND RECEIVE COMPLEMENTS, LEARN TO REFUSE UNWANTED REQUESTS AND LEARN TO COMMUNICATE VERBALLY AND NON VERBALLY

Behavioural self management

BEHAVIORAL SELF-MANAGEMENT TRAINING INVOLVES A SERIES OF STRATEGIES SUCH AS:

- SELF-MONITORING
- SETTING DRINKING LIMITS
- CONTROLLING RATES OF DRINKING
- IDENTIFYING PROBLEM DRINKING SITUATIONS
- SELF-REWARD FOR LIMITED DRINKING

Behavioural self management

- ONE POTENTIAL PROBLEM ARISING FROM THIS PROCEDURE IS THAT DRINKERS FOR WHOM ABSTINENCE IS ADVISABLE MAY SEE THIS STRATEGY AS A MEANS OF “SAFE” DRINKING.
- IF THERE IS DOUBT ABOUT A CLIENT’S ABILITY TO DEAL WITH THIS INFORMATION APPROPRIATELY, IT IS RECOMMENDED THAT THE TECHNIQUE NOT BE USED.
- IF USED IN THE CONTEXT OF A GOAL OF ABSTINENCE, IT SHOULD BE PRESENTED AS A STRATEGY TO COPE WITH A TEMPORARY LAPSE TO DRINKING.

Cognitive Restructuring

- THE GOALS OF COGNITIVE RESTRUCTURING ARE FOR CLIENTS TO **RECOGNIZE WHEN THEY ARE THINKING IN A WAY THAT IS LIKELY TO LEAD TO DRINKING AND TO INTERRUPT AND CHALLENGE THESE THOUGHTS.**
- COGNITIVE RESTRUCTURING IS APPROPRIATE FOR CLIENTS WITH A GOAL OF EITHER MODERATION OR ABSTINENCE.
- EFFECTIVE IF THERE IS COMORBID ANXIETY OR DEPRESSION.

Behavioral marital therapy (BMT)

- PARTICULAR TYPE OF BEHAVIORAL COUPLES THERAPY ON WHICH MUCH OF THE RESEARCH EXAMINING BEHAVIORAL COUPLES THERAPY HAS BEEN BASED
- A BEHAVIORAL CONTRACT BETWEEN THE ALCOHOL DEPENDENT PERSON AND THE PARTNER TO MAINTAIN DISULFIRAM INGESTION.
- “ALCOHOL-FOCUSED SPOUSE INVOLVEMENT” WHICH REARRANGES REINFORCEMENT CONTINGENCIES IN THE FAMILY TO DECREASE FAMILY MEMBER BEHAVIORS THAT TRIGGER OR ENABLE DRINKING AND TO INCREASE POSITIVE REINFORCEMENT FOR SOBRIETY.

Special Groups

WOMEN

- MORE LIKELY TO ABSTAIN FROM ALCOHOL
- MORE LIKELY TO CONSUME LESS ALCOHOL THAN MEN
- MORE LIKELY TO BE ASSOCIATED WITH NEGATIVE MOOD STATES & PHYSICAL PROBLEMS
- IDENTIFY NEGATIVE EMOTIONS AND INTERPERSONAL CONFLICTS AS ANTECEDENTS OF A RELAPSE
- MOOD AND ANXIETY DISORDERS PRECEDE THE ONSET OF SUBSTANCE USE AND DEPENDENCE
- MORE RISKS OF COMPLICATIONS

Special Groups

PREGNANCY

- NICE – NEVER DRINK DURING PREGNANCY ESPECIALLY 1ST 3 MONTHS
- IF WITHDRAWAL SYMPTOMS PRESENT, PHARMACOLOGICAL COVER ON INPATIENT BASIS OFFERED
- RISK-BENEFIT ASSESSMENT TO BE DONE
- TIMING OF DETOXIFICATION RISK-ASSESSED AGAINST CONTINUED ALCOHOL CONSUMPTION
- **CHLORDIAZEPOXID**E-LOW RISK BUT DOSE RELATED MALFORMATIONS OBSERVED.

Special groups

ADOLESCENTS

- HAVE COMPARATIVELY SHORT HISTORIES OF HEAVY DRINKING.
- RARITY OF PHYSIOLOGICAL DEPENDENCE ON ALCOHOL AND ALCOHOL-RELATED MEDICAL COMPLICATIONS.
- MOTOR VEHICLE ACCIDENTS, HOMICIDE, AND SUICIDE
- VALUES AND BEHAVIOR OF THE PEER GROUP
- ASSESS FAMILY INTERACTIONS, INTERNALIZING & EXTERNALIZING DISORDERS.
- **NO DRUGS APPROVED FOR RELAPSE PREVENTION IN <18YRS**
- INTERVENTIONS NEED TO BE CONCRETE & GOAL-ORIENTED

Special Groups

ELDERLY

- UNTREATED MEDICAL ILLNESS
- PRESCRIPTION DRUG ABUSE
- DRUG INTERACTIONS
- PSYCHIATRIC COMORBIDITY
- COGNITIVE IMPAIRMENT
- FUNCTIONAL ASSESSMENT
- NEED FOR SOCIAL SERVICES
- NO DIFFERENCE IN OUTCOME FOLLOWING RX

Special Groups

PHYSICIANS AS PATIENTS

- RELUCTANCE TO ACCEPT HELP
- TENDENCY TO TREAT THEMSELVES
- ONCE IN RX, OUTCOME IS GOOD IF THEY CAN RETURN TO PRACTICE
- TREAT IN SAME WAY AS A LAY PERSON
- SUPPORT GROUPS FOR DOCTORS & DENTISTS IN SOME COUNTRIES

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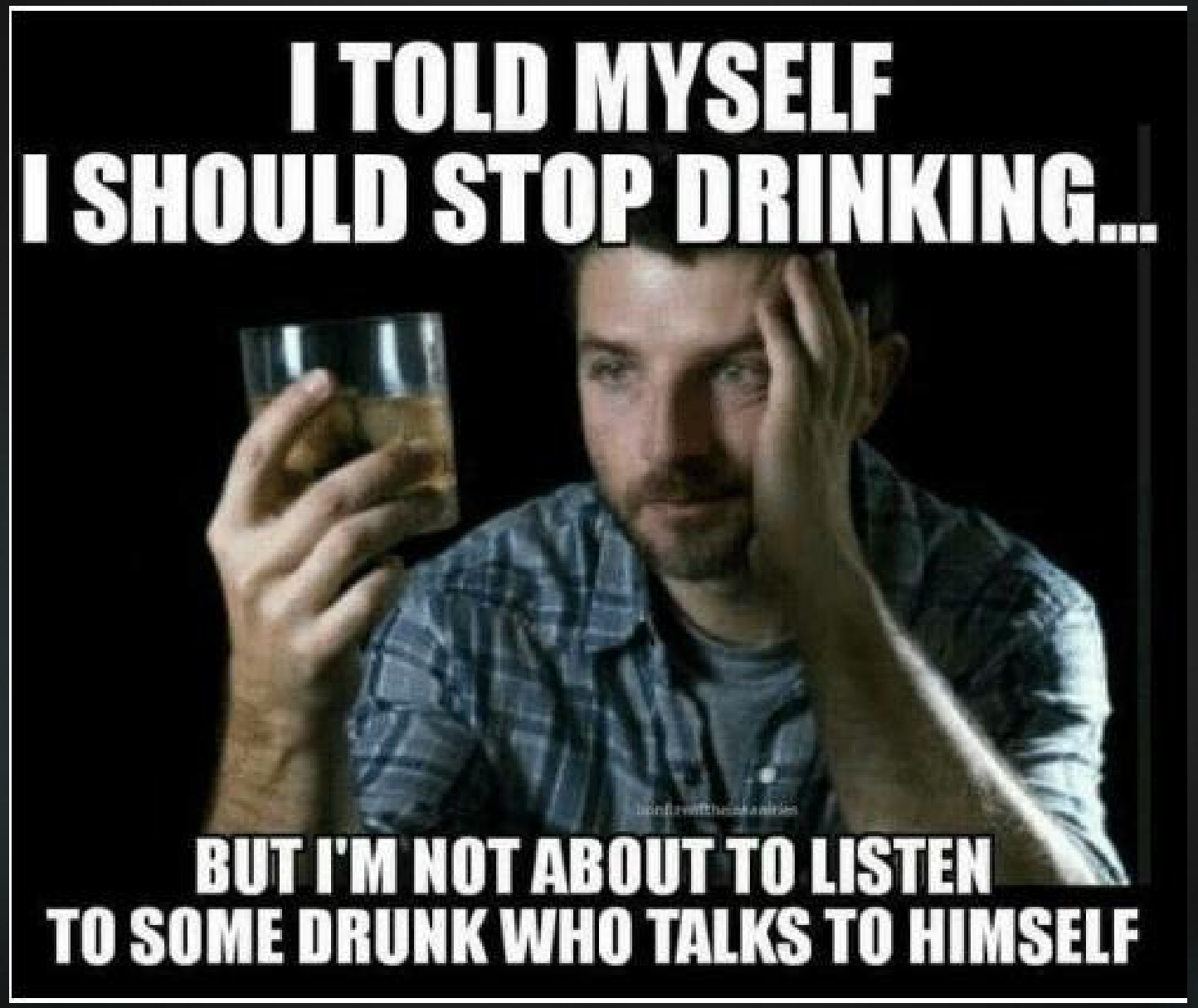
- JHANJEE S. EVIDENCE BASED PSYCHOSOCIAL INTERVENTIONS IN SUBSTANCE USE. INDIAN JOURNAL OF PSYCHOLOGICAL MEDICINE. 2014 APR;36(2):112.

Thank You


I TOLD MYSELF
I SHOULD STOP DRINKING...
BUT I'M NOT ABOUT TO LISTEN
TO SOME DRUNK WHO TALKS TO HIMSELF