Dealing with Alcohol Abuse within the Family

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Introduction

The role of the family in understanding and treatment of alcoholism and substance abuse has been recognised since the 1970s. Before, these problems were believed to be related to genetics and/or individual psychopathology[1]. There are some genetic linkages, but this is only part of the story. Norms for acceptable behaviour with mind-altering substances are first encountered in families. It is acceptable that wine and other alcohol drinks are served with food on a daily basis in our homes. It is part of our culture that every occasion, whether it is winning a football game, a horse race, or a village festa, it is celebrated by freely drinking alcohol.

Furthermore, conditions that exist in families may reinforce maintenance of these behaviours. Once these patterns are established, changing these patterns often involves and affects family members. Successful treatment will virtually always involve all the family[2]. But the most alarming data about substance abuse in Malta was revealed from the European School Survey Project Alcohol and other Drugs (ESPAD) 1995 - 1999. The survey concluded that alcohol remains the number one problem. According to this study the fact that 1 in every 5 respondents said the last time they drank alcohol was at home, indicates the strong reflection of the acceptance of alcohol within our society and indeed within our families[3]. Also Malta compared very high in alcohol use among adolescents less than 16 years of age when compared to other European countries but it ranked very low when compared with regards to illicit drug use.

The Role of the Family Doctor

The family doctor is the most appropriate professional to prevent, detect early and assist in the treatment of established alcoholism in families. A family approach by a family doctor to drug and alcohol problems is important for many reasons. Alcoholics and drug abusers live in families. Only a small percentage of substance abusers live on their own. In this paper we will be tackling alcoholism within the family in a primary care setting.

The strategies used are borrowed from the tobacco dependence literature i.e. the five As technique:

- Ask,
- Assess,
- Advice,
- Assist,
- Arrange.

A Family Approach

Alcoholism runs in families[4]. Persons who have two or more relatives with a history of alcohol abuse are at three times the normal risk of abusing alcohol themselves. Adoption and twin studies have demonstrated that both genetic and family environment increase this risk[4]. Some behaviourists view substance abuse as a conditional behaviour that is reinforced by cues and contingencies within the family. Certain family rituals have been shown to protect against the transmission of alcoholism from one generation to the next[5]. These findings emphasize the importance of obtaining a family history and identifying family members who are at risk.

A family approach allows earlier identification and treatment of alcohol abuse. The earliest problems associated with alcohol abuse are usually psychological and they occur long before any medical complications. Alcohol abuse problems often first present to the family doctor as marital disputes, parent-child conflicts, or work problems in the form of absenteeism[6]. The family doctor may notice a pattern of absence from work after weekends. He will be able to identify the underlying alcohol abuse only if he is aware that such a problem may exist and by exploring these subjects[7]. Family members are usually the first to recognize problems. They may alert the family doctor and ask for help as their first point of contact. It is up to the family doctor to take up the challenge and offers help.

This depends on his training to deal with these problems and acquired skills. Families are a major asset in the assessment and treatment of alcohol abuse problems. Patients who abuse alcohol often deny having a problem. Family members may even share in the denial. The doctor alone will not be able to break down the denial but together with the family he or she can more effectively negotiate with the patient and proceed with the treatment of the whole family. Family treatment has been shown to be helpful both to initiate treatment and to increase the likelihood of success[8]. Family based treatments are currently recognised as among the most effective approaches for adolescent alcohol and drug abuse[9].

Doctor barriers to detection

There are a number of reasons why the family doctor may not detect alcohol abuse at an early stage. The first reason might be lack of education and training in his university days.

Early signs of abuse are mostly psychosocial not biomedical, as a result, bio medically focused doctors may be lead away by the psychological symptoms and s/he remain unaware of the problem. Certain misconceptions on the doctor's part may also act as a barrier to early detection. Even if it is detected early the doctor may not believe that alcohol abuse is a treatable condition. Another reason may be lack of training in treating such conditions and he feels helpless to deal with it. He or she may not be aware of the resources available at community level and he forms a screen of pessimism in his mind which makes him think that it is not worthwhile to treat these patients so he or she may not even try to screen for abusers when it is not so obvious to detect them.

Denial on the doctor's side is perhaps the most significant clinical barrier to detection. The family doctor may be reluctant to go into the psychological problems of the patient and prefers not to change his role from a clinician to a counsellor. Some family doctors are uncomfortable with this change of role. The family doctor may also be short for time and tries to avoid an anticipated increase in time for the visit. Some doctors fail to distinguish between social drinking and alcohol abuse due to their own amount of drinking which is legitimate for them.

At-risk drinking

Men and women have different rates of metabolism so the amount of drinking allowed depends on the gender.

According to the National Institute on Alcohol Abuse and Alcoholism, for women the limit is set at one drink per day or seven drinks per week; for men the quantity is double that[10].

The Five As Technique

Ask

Studies show that patients rarely bring up this problem when consulting their family doctor[11]. So the doctor has to screen patients by specifically asking the patients about their drinking habits. Useful direct questions are as follows:

1. "How much alcohol do you drink?" (Rather than, "Do you drink alcohol?")
   It is helpful to get an average for a week including the weekend. Be sure about the actual quantities by specifying the volume of the beer bottle.
2. "Have you ever had problems with your health, your work, or your family because of drinking?"
   This question has been shown to be particularly effective in identifying alcoholic patients[12].

Include these questions routinely with other routine questions when taking the medical history. Show interest but do not be surprised by the answers the patient gives you. Avoid being judgemental. Patients do not consider drinking to be a disease unless there are medical complications. So at this stage most patients are still in the precontemplation stage of change according to the Transtheoretical Model of Behaviour Change (Proschaska, 1979).

There are a variety of other quick screening and case identification tools that have been developed for use in primary care setting to follow up suspicion of a problem. The most extensively studied instrument, the CAGE questionnaire[13].

C Have you ever felt you ought to Cut down on your drinking?
A Have people Annoyed you about your drinking?
G Have ever felt Guilty 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 (Eye Opener)?

Two or more positive responses are considered clinically significant.

Finally another direct question which was found to have good sensitivity and specificity is:

"When was the last time you had more than five (four for women) drinks on one occasion?" [14].

Assess

When it has been established that a drinking problem is present an accurate assessment needs to be done.

Whenever possible, involve family members as part of the assessment after taking permission from the patient if he is over 18 years of age. Family members are the most important allies in the treatment process. They may shed different light on the problem and give more accurate information, including exacerbating factors. At this point the patient and family are being moved to the next stage of change that of contemplation stage. Investigate how the problem is affecting them. Go into details about:

1. the exact quantity drunk
2. the time of drinking
3. the place and social setting

It is very important to assess the patient's readiness to change and stop drinking. The family of the person with alcohol-related problems can still be offered support and assistance even if the person with the alcohol problem refuses to receive any help. The doctor can go back to the previous stage and try again in the next occasion he or she meets the patient again whatever the reason. It is only when the patient shows a motivation to change the doctor can move on to the next stage which is preparation stage.

Advise

The doctor now needs to persuade the patient that the decision he took was the right one. He should tell him the benefits from stopping drinking. The advice is based on the five Rs:

- Relevance
- Risks
- Rewards
- Roadblocks
- Repetition

1. Relevance

Link the risk -related behaviour to current problems i.e. medical, legal or social whenever possible. For example,

explain that drinking can cause stomach ulcers or drinking can lead you to financial problems or problems at work.

2. **Risks**
   Describe future problems he may have like marital problems, mental problems and medical problems due to liver damage.
3. **Rewards**
   Help identify some of the rewards he gets together with his family if he stops drinking like improvement in his health, financial situation better relations with his family and work place.
4. **Roadblocks**
   Anticipate any difficulties and challenges he may have and advice how he can cope with them. He needs to be told about possible physical consequences of withdrawal so that he will be able to cope and later on to be helped with them.The steps should be repeated if need be in future visits. Persistence will pay off with these cases.

Assist

If the patient still shows that he wants to change he can be moved to the next stage where action is taken. A date for stopping must be set. The doctor must be persistent and strict that this is kept. The assistance will be in the form of counselling sessions and adjuvant pharmacotherapy. The patient may be treated for a concomitant depression or anxiety or for his withdrawal symptoms. Sulfiram can be used. At this stage NGOs like Sedqa, Oasi and Supporting groups like AA can be involved. Other community resources like a social worker can also be useful.

Studies show that brief interventions are as effective as long interventions and better than no interventions at all[15]. According to Fleming and colleagues these brief interventions consist of two 15-minute visits 1 month apart and one follow-up phone call. In these visits patients are given feedback, repetition of some of the advice given, a list of drinking cues, renewal of the drinking agreement and dealing with any relapse.

Arrange

These interventions will lead to the last stage of change which is the maintenance stage of the change so that the patient will keep sober and alcohol free. This will be done by arranging follow-ups. Alcohol abuse is a chronic problem and relapses can occur so the process can be repeated at any stage. Positive encouragement is always helpful and the family is always kept involved so that when a change in the behaviour is noted the patient is referred back immediately. Sometimes in recurrent relapses the help of other professionals like counsellors, psychotherapists and psychologists may be needed. At times the doctor cannot handle the problem alone. On routine visits the family doctor will screen for relapse and assess the family situation and look for any problems which may lead to relapse. The patient may be experiencing a problem in the family. In these cases a family therapist may be useful. If the patient and his family are referred the doctor will remain the point of contact and the therapists are asked for feedback which will be useful for the continuous care of the patient and family.

Conclusion

Alcohol abuse is a common and serious but treatable chronic illness affecting not only the patient but the whole family. Family doctors need to be alert to the potential in all their patients. A family orientation gives the family doctor an advantage in the early diagnosis and treatment of this disorder. Involvement of the family increases the success of the treatment. Family-oriented treatment is essential to change the context within which the problem arose and to help patients and families establish and maintain new, healthier lifestyles.

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