PSYCHIATRIA ET NEUROLOGIA JAPONICA

Special Feature Article

Dealing with Alcohol-dependent Patients with Low Motivation for Abstinence

Toru SAWAYAMA
Sagamigaoka Hospital
Psychiatria et Neurologia Japonica 123: 482-486, 2021

Abstract

The new diagnostic and treatment guidelines for alcohol and drug use disorders recommend that alcohol consumption reduction be a provisional treatment goal in terms of preventing withdrawal from treatment, even if severe alcohol-dependent patients who should choose to stop drinking disagree with abstinence. This recommendation has made it possible to treat alcohol-dependent patients with low motivation for abstinence flexibly, while respecting their intentions without conflicting with them. By considering alcohol consumption reduction as one of the treatment goals for changing drinking behavior, rather than as a resistance to treatment, it is expected that conflicts with patients will be reduced and it will be easier to build the patient-medical staff relationship. It is also useful to understand and practice the essence of motivational interviewing, which is positioned as one of the main psychosocial treatments in the new guidelines, to help patients make better choices regarding treatment goals.

Keywords: alcohol dependence, guideline, treatment goal, alcohol consumption reduction, motivational interviewing

Introduction

In the "New Guidelines for the Diagnosis and Treatment of Alcohol and Drug Use Disorders" (hereafter referred

to as "New Guidelines") revised in 2018, "reduction of alcohol consumption (so-called controlled drinking)" was adopted for the first time as a recommendation regarding treatment goals for alcohol dependence 2) (Table). The most notable point of this recommendation regarding treatment goals is that while the principle treatment for alcoholism remains "abstinence", "reduction of alcohol consumption" can be a treatment goal in cases of mild addiction with no obvious complications, and even in cases of severe addiction (Inpatient treatment is required, social and family life is difficult due to drinking problems, serious organ damage, alcohol withdrawal requiring emergency treatment, etc.), it can be considered as an interim treatment goal in order to prevent dropping out of treatment if the person does not agree with abstinence. Traditionally, when an alcoholic (judged to need abstinence from alcohol) does not consent to abstinence treatment, medical personnel often struggle to deal with the situation, but it is hoped that the recommendation that reduction of alcohol consumption may be made an interim treatment goal will enable diverse responses to "Alcoholics who need abstinence but lack motivation." This article examines practical treatments through "Hypothetical cases of need for abstinence but insufficient motivation" and describes the essence of motivational interviewing, which is positioned as one of the main psychosocial treatments in the new guidelines.

I. Hypothetical cases of insufficient motivation despite the need for abstinence

1. Hypothetical case A: A patient who agreed to abstain from alcohol and continued abstaining after we suggested abstinence to him.

A 58-year-old man. Company employee. Lives with his wife.

History of Present Illness: He has alcoholic cirrhosis of the liver and has been hospitalized three times for ruptured esophageal varices in the gastroenterology department of another hospital. He has also had alcohol withdrawal symptoms such as hand tremor for the past 4 to 5 years. The gastroenterologist recommended that he and his wife visit an outpatient alcohol clinic.

Treatment plan and goal: The patient said: "Drinking alcohol is necessary to relieve stress, so I don't want to stop. I want to take care of myself and drink less". However, it was decided that it was necessary to abstain from alcohol because of the serious organ damage of alcoholic cirrhosis. Accepting the feelings of the individual and emphasizing that he had the final say, if

he abstains from alcohol, the merits of abstinence, such as "reducing the risk of re-rupture of esophageal varices," "preventing the progression of cirrhosis," and "becoming accustomed to a life in which one does not drink if one continues to abstain from alcohol," were explained, and abstinence was proposed.

Treatment course: The patient agreed to abstain from alcohol, and continued abstaining while visiting the hospital.

2. Hypothetical case B: A patient who agreed to abstain from alcohol after that was proposed, but had difficulty staying sober, and hoped to reduce his alcohol consumption.

A 62-year-old male. He runs his own restaurant (tavern). Lives with his wife and daughter.

History of present illness: He has been hospitalized twice for alcoholic pancreatitis in the gastroenterology department of another hospital. For the past year, he has been drinking from the morning and sometimes could not open his restaurant. This was the third time he was hospitalized by a gastroenterologist due to pancreatitis, and his wife recommended that they visit an outpatient alcohol clinic.

Treatment plan and goal: The patient wished to reduce his drinking, saying: "Drinking alcohol is necessary to drink with customers at work and relieve stress. I will be careful not to drink too much from now on". However, because he had a serious organ disorder, alcoholic pancreatitis, which interfered with his social life (work), we judged that abstinence from alcohol was necessary, and when we suggested abstinence treatment, he agreed to abstain from alcohol and chose to take anti-alcohol drugs.

Treatment course: He stopped drinking for about 2 weeks, but said: "I still want to drink after work," and started drinking 1 ~ 2 220-mL cups of soju every night. Although he no longer drinks alcohol in the morning, he has chronic pancreatitis, and so we have explained the necessity of abstaining from alcohol, but he continues to drink alcohol in the same manner (although there is some increase or decrease). One year has passed without exacerbation of pancreatitis.

3. Hypothetical case C: A case involving a patient who was recommended to abstain from alcohol but wanted to reduce the amount of alcohol consumed, and continued to reduce that amount.

A 66-year-old woman whose husband died 8 years ago and has lived alone ever since. Her eldest son and his family live nearby.

History of present illness: After her husband's death, her alcohol consumption increased. She developed consciousness disturbance and visual

hallucinations, and was admitted to the psychiatric department for alcohol withdrawal delirium. The withdrawal delirium improved in about a week.

Treatment plan and goal: Since she showed symptoms of alcohol withdrawal requiring inpatient treatment, we judged that she needed to abstain from alcohol and proposed abstinence treatment. However, the patient stubbornly stated: "I can't quit drinking completely. I drink when there are gatherings or events. If I am told to quit drinking completely, I won't even go to the hospital". Therefore, the patient's desired opportunity-based drinking was set as the treatment goal, and the patient was monitored.

Treatment course: Three years have passed since discharge from the hospital, and the patient does not drink except for during dinner with friends and family once every month or two, and there has been no relapse of delirium due to alcohol withdrawal.

4. Hypothetical case D: The patient was proposed to abstain from alcohol, but he wanted to reduce his alcohol consumption. However, he agreed to abstain from alcohol consumption because it was difficult for him to continue to reduce his intake.

A 49-year-old male office worker. Company employee. He has never been married and lives alone.

History of present illness: He had been drinking too much on weekends and was late for work or absent from work at the beginning of the week. This time, he had been drinking continuously during the summer vacation and was unable to come to work after the vacation, so he called 119 himself and was admitted to a secondary emergency hospital because of appetite loss, nausea, and vomiting. He was taken by his concerned mother and sister to the outpatient alcohol clinic for the first time.

Treatment plan and goal: The patient had difficulty in social and family life due to continuous drinking, and we judged that he needed to abstain from alcohol. However, the patient said: "I drank too much this time. I'll be careful from now on, so I'll be fine," and wished to reduce his drinking (he agreed to go to the hospital).

Treatment course: However, the patient continued to drink during the New Year's and Golden Week holidays, and when we again suggested abstinence from alcohol, the patient decided to abstain. Since then, he has generally continued to abstain from alcohol, although he occasionally relapses every few months to every six months, and two years have passed without continuous drinking.

5. Hypothetical case E: The patient was

proposed to abstain from alcohol, but hoped to reduce his drinking. He had difficulty continuing to reduce his intake, but he wanted to continue to reduce his drinking.

A 72-year-old man who lives with his wife. After retiring at age 60, he worked part-time until age 68, but has been living on a pension ever since.

History of present illness: After retirement, he began drinking alcohol in the morning, and the amount of alcohol he consumed increased. Gradually, he began to fall when intoxicated and became incontinent. He and his wife visited an outpatient alcohol clinic after he was rushed to the emergency room due to bleeding from his head after a fall.

Treatment plan and goal: Because his drinking made his family life difficult, we judged that he needed to abstain from alcohol and proposed abstinence treatment. However, the patient said: "I have nothing to look forward to but alcohol. It's okay if you're careful not to drink too much." and he wanted to reduce his drinking.

Treatment course: The patient was unable to reduce his alcohol consumption, and repeatedly fell down and became incontinent when intoxicated. We again suggested abstinence treatment, but he continued to request a reduction in his alcohol consumption, saying: "I'm fine. I'm not drinking as much as my wife says." Now, he continues to visit the clinic with his wife, and although he drinks less than before, he sometimes drinks too much and falls down or becomes incontinent.

II. Considerations regarding hypothetical cases A through E

Hypothetical cases A through E were all judged to require abstinence treatment because of serious organ damage, alcohol withdrawal symptoms requiring urgent treatment, or difficulties in social and family life due to drinking problems, but the patients' motivation to abstain from alcohol was insufficient. In cases A and B, the patients agreed to abstain from alcohol when the abstinence treatment was proposed by the physicians, but in case B, the patient resumed drinking and wished to reduce his alcohol consumption (so-called controlled drinking) again as a treatment goal. Hypothetical cases C through E did not agree to abstinence from alcohol and wanted to reduce their alcohol consumption, despite suggestions from their health care providers. If abstinence from alcohol was the only goal of treatment, as in the past, such a request (i.e., reduction in alcohol consumption) would be considered a denial of or resistance to the disease or treatment. However, the new guideline does not consider alcohol consumption reduction as resistance to treatment,

but as an option for improved drinking behavior. In other words, abstinence from alcohol and alcohol consumption reduction are not positioned as conflicting and incompatible treatment goals. This change in thinking regarding treatment goals is expected to reduce conflict with patients and facilitate the development of a patient-provider relationship, thereby making patients less likely to drop out of treatment.

In addition to (1), the group of alcoholics who were able to accept abstinence treatment, which was the main treatment target of conventional alcoholism treatment, Yuzuri suggested that the following two groups could be added to the treatment target for effective treatment goal setting. The two groups are: (2) those who cannot agree to abstain from alcohol but can maintain a therapeutic relationship with controlled drinking, and (3) those who cannot give up alcohol by any means. He stated that for (2), it is effective to provide interventions that lead to eventual abstinence (while maintaining controlled drinking as the immediate treatment goal), and for (3), it is effective to provide interventions that reduce the risk of health problems for the patient and others as much as possible 4). For case D, the decision was made that a therapeutic relationship could be maintained if the amount of alcohol consumed could be reduced, so the immediate treatment goal was to reduce the amount of alcohol consumed, but eventually the patient accepted that it was difficult to continue reducing the amount of alcohol consumed and stopped drinking altogether. Even if the patient continues to wish to reduce his/her alcohol consumption despite time-consuming motivation, as in hypothetical case E, it is necessary to respect the patient's wishes and maintain the therapeutic relationship with the goal of drinking as little as possible to reduce the risk of health hazards.

In general, alcoholics with less severe alcohol dependence have a higher probability of achieving reduced alcohol consumption 3), but as stated in the new guidelines, no unified view on the severity of alcohol dependence has been reached 2). In actual clinical practice, it is not uncommon for patients who were considered to need to abstain from alcohol consumption to continue to reduce their alcohol consumption, as in cases B and C. In such cases, it is difficult to predict in advance which patient will be able to continue to reduce their alcohol consumption, so it is necessary to maintain the therapeutic relationship and support them if their alcohol consumption decreases, and conversely, if the patient's alcohol consumption increases, it is necessary

to respond flexibly to their needs, for example, by proposing a new goal of abstinence from alcohol consumption. In any case, it is important to guide patients so that they can make better choices for themselves, rather than having a medical provider unilaterally impose treatment goals on them.

III. How to deal with "patients who need abstinence but lack motivation" from the viewpoint of motivational interviewing

Finally, as a health care provider, I would like to discuss the essence of motivational interviewing, which is positioned as one of the main psychosocial treatments in the new guidelines, in order to help patients make better choices regarding their own treatment goals.

Motivational interviewing is an interviewing technique 1) to strengthen the patient's motivation and determination to change their behavior, and it is designed to stimulate and strengthen the patient's desire to change their behavior while treating the patient in an accepting and empathic manner. From the viewpoint of motivational interviewing, the following points should be considered when working with a patient who requires abstinence but lacks motivation:

1. Suppress the desire to correct the patient's words or actions and avoid imposing the medical professional's common sense or opinion.

If a medical professional expresses an opinion (e.g., the need for abstinence) without asking the patient about his/her thoughts and feelings, it is unlikely that the patient will accept the opinion without question.

2. Be receptive and empathetic to the patient.

Listen to the patient without criticizing or denying what he/she says, try to understand the patient's thoughts, feelings, and situation, and convey this understanding to the patient (e.g., "You need alcohol to relieve stress..." or "You must feel lonely to quit drinking completely.") Build a trusting relationship with the patient by being receptive and empathetic.

3. Recognize the other side of the patient's ambivalence (the desire to change and idea of change) and elicit or reinforce it.

For example, if a patient who seems to need to stop drinking says: "I have a desire to reduce my drinking," instead of denying it by saying: "You need to abstain from alcohol, not moderate drinking," it is useful to respond in a way that reinforces or elicits statements toward change, such as: "You have a feeling that your current way of

drinking is bad," or "What are you worried about with your current drinking?".

4. Provide advice and information while respecting the patient's thoughts and feelings.

Before the medical provider advises the patient about future treatment goals, the patient's own intentions should first be ascertained. Even if the patient wishes to reduce his or her alcohol consumption, their intention should be accepted (not consented to), and information about the "need for abstinence" should be provided and abstinence treatment should be proposed (since each patient has different motivations and reasons for changing his or her drinking behavior, information should be provided with an awareness of what will resonate with the patient). The final decision on the treatment goal is left to the patient himself/herself.

5. Continue the involvement, repeating steps 1-4.

If the patient does not agree to treatment, the next step is not to reprimand the patient, but to continue to work with them, repeating steps 1-4. If it is difficult to move immediately toward abstinence treatment, the next step is to work with the patient to establish a patient-provider relationship that will encourage the patient to continue treatment.

Conclusion

Needless to say, there is no one-size-fits-all technique that works for all alcoholics with insufficient motivation. This is because each patient has different motivations and reasons for changing his or her drinking behavior, even among the same alcoholics. The motivation for patients to change their drinking behavior lies within the patients themselves, not within their health care providers. Therefore, it is important to search for and elicit "the patient's own reasons to change" rather than imposing "reasons for change from medical staff". The new guideline recommends that, in cases of severe alcohol dependence where the patient does not agree to abstain from alcohol, a reduction in alcohol consumption should be made an interim treatment goal in order to reduce the likelihood of the patient dropping out of treatment. This allows for a flexible approach, respecting the patient's wishes without conflict. It is important for health care providers to support patients so that they can make better choices for themselves, rather than setting treatment goals unilaterally as experts. If it is difficult for the patient to immediately move toward treatment goals, such as continued abstinence, it is

sometimes necessary to first engage with the patient with the goal of building a patient-provider relationship that will allow the patient to continue treatment.

There are no conflicts of interest to disclose in connection with this paper.

References

1) Miller, W. R., Rollnick, S.: Motivational Interviewing: Helping People Change, 3rd ed. Guilford Press, New York, 2013〔原井宏明監訳，原井宏明，岡嶋美代ほか訳：動機づけ面接第3版(上・下)．星和書店，東京，2019〕

2) 新アルコール・薬物使用障害の診断治療ガイドライン作成委員会監，樋口 進，齋藤利和ほか編：新アルコール・薬物使用障害の診断治療ガイドライン 新興医学出版社，東京，2018

3) Witkiewitz, K., Pearson, M. R., Hallgren, K. A., et al.: Who achieves low risk drinking during alcohol treatment? An analysis of patients in three alcohol clinical trials. Addiction, 112 (12); 2112-2121, 2017

4) 杠 岳文：アルコール使用障害に対する「断酒を目的とした治療」の適応．医事新報，4775; 62-63, 2015

表　アルコール依存症の治療目標に関する推奨事項

・アルコール依存症の治療目標は，原則的に断酒の達成とその継続である
・重症のアルコール依存症や，明確な身体的・精神的合併症を有する場合，または，深刻な家族・社会的問題を有する場合には，治療目標は断酒とすべきである
・上記のようなケースであっても，患者が断酒に応じない場合には，まず説得を試みる．もし，説得がうまくいかない場合でも，そのために治療からドロップアウトする事態は避ける．一つの選択肢として，まず飲酒量低減を目標として，うまくいかなければ断酒に切り替える方法もある
・軽症の依存症*1で明確な合併症を有しないケースでは，患者が断酒を望む場合や断酒を必要とするその他の事情がない限り，飲酒量低減も目標になりうる
・理想的には，男性では 1 日平均 40 g 以下の飲酒，女性では平均 20 g 以下の飲酒が飲酒量低減の目安になる*2
・上記目安にかかわらず，飲酒量の低下は，飲酒に関係した健康障害や社会・家族問題の軽減につながる

*1依存症の重症度に関する統一的見解はない．ICD-10 の診断項目を満たした数や AUDIT（Alcohol Use Disorders Identification Test）の点数などが参考になる．
*2この目安は，厚生労働省による第二次健康日本 21 の「生活習慣病のリスクを上げる飲酒」の基準をもとに作成した．
（文献 2 より一部改変して引用）

Table Recommendations regarding treatment goals for alcoholism

・The goal of treatment for alcoholism is, in principle, to achieve and maintain abstinence.
・In cases of severe alcoholism, with clear physical or mental complications, or serious family or social problems, the goal of treatment should be abstinence.
・Even in these cases, if the patient refuses to abstain from alcohol, the first step is to try to persuade him or her to abstain. If persuasion is unsuccessful, the patient should not drop out of treatment for that reason. One option is to start with the goal of reducing alcohol consumption, and if that does not work, then switch to abstinence.
・In cases of mild dependence*1 with no obvious complications, reduction of alcohol consumption can be a goal, unless the patient wants or has other circumstances that necessitate abstinence.

・Ideally, the guideline for reducing alcohol consumption is an average daily intake of 40 g or less for men and 20 g or less for women*2.
・Regardless of the above guidelines, a reduction in alcohol consumption will lead to reductions in health, social, and family problems related to alcohol consumption.
*1 There is no unified view on the severity of dependence; the number of ICD-10 diagnostic items met or the score of AUDIT (Alcohol Use Disorders Identification Test) can be used as a reference.
2 This guideline was developed based on the criteria for "alcohol consumption that increases the risk of lifestyle-related diseases" in the Second Healthy Japan 21 by the Ministry of Health, Labour and Welfare.
(Cited with some modifications from Reference 2)