PSYCHIATRIA ET
NEUROLOGIA
JAPONICA

*This English manuscript is a translation of a paper originally published in the Psychiatria et Neurologia Japonica, Vol.123, No.8, p.500-505, which was translated by the Japanese Society of Psychiatry and Neurology and published with the author's confirmation and permission. If you wish to cite this paper, please use the original paper as the reference.

Special Feature Article

Memorandum of Alcoholism

Yuki YAMASHITA
Life Support Clinic
Psychiatria et Neurologia Japonica 123: 500-505, 2021

Abstract

Alcohol addiction, combined with the legality of drinking, makes it difficult for patients to be motivated to treat. This paper introduces the author's findings and ingenuity, focusing on "motivation for patient treatment". First, we consider "why people become addicted" from the perspective of cognitive psychology, and describe typical medical examination scenes in clinical practice. Regarding the motivation of the main subject, we explain that it is important for the patient to thoroughly understand addiction, and that the aim of treatment is to "increase the patient's willpower to stop drinking" and to "not increase their willingness to drink", and why it is important to think about these two factors separately. Finally, we discuss "the essence of harm reduction in alcoholism".

Keywords: alcoholism, motivational interviewing, liar, harm reduction

Introduction

"The patient was involuntarily hospitalized because of drinking, but he drank alcohol while in the hospital and was forcibly discharged from the hospital". In my work as an outpatient addiction specialist at a clinic in the city, I often encounter such cases. Strangely enough, in alcoholism, patients who are involuntarily hospitalized because of their "inability to quit drinking" can be involuntarily discharged because of

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

their symptoms. Of course, I understand that there are various circumstances in each case. However, if it were self-injury rather than alcohol, patients who were involuntarily hospitalized because of self-injury would not be involuntarily discharged because of repeated self-injury during their hospitalization. Why is it that only alcoholism is given the cold shoulder in psychiatric care, when, depending on one's point of view, self-injurious drinking is also involved? This is probably due in part to the fact that patients who say they want to quit but do not take action are the target of projection by treatment providers, and also due to the defense mechanism of treatment providers who cannot logically explain the necessity of abstinence to patients who have not yet experienced bottoming out because alcohol is still legal. In this article, I would like to discuss the author's thoughts on the theme of "how to connect patients who have not yet experienced bottoming out to treatment".

I. How to know "who you are"

If the question is asked, "Why do people become addicted?" one can say, "Because we are human beings as well as hominid". The word "human" is written as "between people", which tells us that people cannot live alone. Imagine a situation in which a person washes ashore on a deserted island. At first, everyone will be desperate to secure food, clothing, and shelter. However, even if they were able to meet all of these needs, they would not be satisfied. They may think of their hometown and try to escape, and if they see a ship-like object in the distance, they will shout "help" with all their might. And the object of help is not the body, but the mind.

Next, if we consider "Why can't people live alone?" the answer is "Because people think about who they are" and "Because evaluation by others and comparison with others are indispensable to find the answer to this question". In other words, a person may define himself or herself in terms of the human species, as a mammalian hominid, Asian in race, male in sex, etc., but he or she as a human being cannot be defined without the existence of others. By interacting with others, people obtain a variety of emotions and find meaning and significance in their lives. In this paper, we define "good dependence" as those who bring positive feelings such as self-importance, solidarity, security, and freedom. On the other hand, the mind of a person without good dependence is a desert island, where alcohol consumption functions as a pseudo "good dependence". This is because alcohol

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

induces feelings of intoxication and exaggerated self-importance and freedom, and feelings of tranquility, solidarity, and security. In other words, alcohol dependence is not a person, but an act of gaining self-awareness through drinking. However, because it is an illusion, the person's mind cannot be saved. Therefore, the success of treatment depends on whether or not the therapist can become a good dependent of the patient, and for this purpose, it is essential to first carefully listen to the patient's story and give him or her a sense of security and self-importance.

II. What constitutes "dependence"?

It is not uncommon to be asked, "How much do I have to drink to be an addict?" at the first visit. The author has long believed that human happiness is "doing what you love with the people you love" and "cherishing what your loved ones cherish". Therefore, if a person drinks while feeling that he or she is "sacrificing important people and important things by drinking", it can be said that he or she is mentally ill. However, it is difficult to provide a satisfactory answer to the question of "How much do I have to drink to be an addict?" This is because people have a strong fear of "people who try to change them". When treatment guidelines or self-administered questionnaires are presented to them, they may rebel, saying, "Well, medically, that may be true, but it doesn't apply to me". It is true that if a patient is told by someone he or she has never met before that "you meet the diagnostic criteria for addiction and need treatment", and if the patient says, "Okay, I understand. Please take care of me", he or she may not have an addiction. Therefore, the author tries to deflect the "How much do I have to drink to be an addict?" question by asking the opposite question. For example, if the patient cites "stress" as the reason for drinking, I ask, "Don't you drink when you are free or happy?" and if the patient cites "because it tastes good", I ask, "Have you ever paid for a drink that does not taste good?" People always tend to think of their problems as "just barely okay". Therefore, in order for the patient to develop an awareness of the disease without experiencing a bottoming out, it is necessary for the patient and the therapist to work together in a philosophical attitude toward "why do I drink?"

III. What is "good alcohol"?

As mentioned earlier, discussing the "taste" of alcoholic beverages is important for patients to gain a sense of awareness of their disease. In the outpatient clinic, I often meet patients who answer "because it tastes good" as

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

the reason for their drinking. However, if we ask, "Then, do you drink only local beer or wine that emphasizes taste?", the answer is usually inexpensive alcohol that emphasizes quantity over quality, or chuhai (a beverage with a high alcohol content). Also, many people misunderstand that alcohol is essentially a tasteless drink. In order to make it taste good, fruit juice and sugar are added, or the drink is chilled or carbonated. Even agar becomes jelly when sugar and fruit juice are added, and even water becomes cider when sugar and carbonated water are added. In other words, there is no such thing as "good-tasting alcohol", but rather a product that hides its inherent alcohol unpleasantness by "letting it sit in a barrel" or "polishing the rice". Some people say that sake tastes like water as a compliment when they taste it, but the author may not be the only one who thinks, "If that's the case, why don't you just drink water?" Then, why do people ingest such tasteless alcoholic beverages in all ages and in all countries? The first reason is that drinking causes the release of dopamine in the brain, which brings about an emotion called "pleasure", and the second reason is that intoxication gives people the illusion that they have "relieved stress". Therefore, drinking for the former effect is rational, while drinking for the latter effect is irrational.

IV. For family members when a patient is hospitalized

When a patient is hospitalized, many family members say, "A weight has been lifted from our shoulders". However, in the case of alcoholism, there are only a few cases in which "hospitalization leads to recovery", and as mentioned earlier, "forced discharge due to drinking during hospitalization" may occur. If this were the case with schizophrenia or Type I bipolar affective disorder, there may be cases in which patients “acquire a sense of illness after multiple hospitalizations”, but with alcoholism, the more frequent the hospitalizations, the more the patients distrust psychiatric treatment, and in many cases, their relationships with their families deteriorate. Of course, there are cases in which patients continue to stay sober for a long time after inpatient treatment. However, in order for this to happen, it is essential for patients to be connected to quit drinking self-help society meetings or day care after discharge, to meet compatible partners or attending physicians, or to become involved with organizations or people they did not even know existed before their hospitalization. Therefore, the essence of the disease must be explained to the patient’s family, such as “the patient can lead a social life only during the

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

period of abstinence", "the patient's ability to control his/her own alcohol consumption will not recover", "hospitalization is neither a goal nor a start, but an emergency response", and "the real treatment begins after discharge when the patient can freely buy alcohol". Otherwise, the day when the family becomes "good dependents" of the patient will become more distant due to excessive expectations of inpatient treatment.

V. Why do patients lie?

Many family members accuse the patient in front of the attending physician, saying, "He is really a liar," or "I have been deceived by him many times in my life." Of course, the family members' feelings of resentment are understandable. However, if I ask, "Well, what if he honestly told you that he had been drinking?", the family tends to answer, "Of course I would be angry". In other words, the patient is not lying because he wants to lie, but because of the structure of "being scolded if he tells the truth." Therefore, it is important to inform the family of the reality that "this disease leads to recovery through multiple re-drinking (slips)" and that "patients do not have to lie if they are not scolded when they tell the truth about their slips". Unfortunately, however, there are cases in which it is difficult to gain their understanding, perhaps because of years of hardship and resentment, and they say, "It is true that he still lied", so the author also provides the following explanation.

VI. Multiple personalities, not liars

The term "multiple personalities" here does not refer to dissociative identity disorder, but rather to "the simultaneous existence of multiple wills under a person's consciousness". For example, let's say that a woman named Ms. A thinks, "I want to go to Okinawa for New Year's vacation this year". However, when she researches, she finds that the price of travel during that period is about three times the usual price, so she decides to "go somewhere other than Okinawa for New Year's vacation". She then learned that she could go to Hawaii for the same price as she had expected to spend on going to Okinawa, so she decided to "go to Hawaii instead of Okinawa for New Year's". However, no one would call Ms. A a "liar" for changing her opinion based on a single piece of information. In other words, when she was thinking "Okinawa for New Year's", there were many other places she wanted to go besides Okinawa, but she had just integrated various circumstances and decided "I want to go to Okinawa." If Ms. A had a millionaire lover and he had asked her to go on a space trip during the New Year's holiday, and she had

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

readily agreed, she would have had the desire to go to space during the New Year's holiday in her consciousness. However, until she receives his invitation, she is unlikely to be aware of her desire due to its lack of feasibility. Again, everyone has multiple personalities. For example, even while reading a book, there are various willful thoughts in the subconscious, such as "I'm thirsty", "I need to go to the restroom", and "I have to finish that work". However, we are not aware of them until they take first place in the "majority vote in the subconscious". Now, let me apply this story to the psychology of addicts. It is understood that various wills for alcohol always exist in the patient's subconscious, of which they are unaware. In other words, when the patient says in front of their family that they will never drink again, they is not lying. However, the patient's will to drink also exists under their consciousness, such as "I will drink again after I stop drinking for a while" or "I should be able to get along with alcohol again someday", etc. As the memory of the drinking failure fades with time, the patient's "will to abstain from alcohol" also declines, and when it falls below his conscious "will to drink", they slip. At some point, the family will realize this and question the patient, but the reason why the patient does not tell the truth about their drinking is not because they are a liar, but because of the family structure, as mentioned earlier.

VII. Thinking about treatment

There is always a "self that wants to quit" and a "self that wants to drink" under the patient's consciousness. Therefore, no matter how many years of abstinence a patient has maintained, their "intention to abstain from alcohol: intention to drink" is not "10:0" but "6:4" or "5.1:4.9". And since the intention to abstain from alcohol and the intention to drink do not always work in tandem like a seesaw, expressions such as "12:11" or "2:1" may be more appropriate at times. A patient who was sober 6:4 may slip to a 6:7 drinking intention only if they are severely harassed at work. If they loses their wallet, their drinking intention may drop significantly to "6:1" until they get their money back. Therefore, the treatment of this syndrome is effective by approaching each of the subconscious "intention to abstain from alcohol" and "intention to drink" separately.

VIII. Raising the "will to abstain from alcohol"

Many treatment providers and family members try to increase the patient's "intention to abstain from alcohol" by explaining the benefits of abstinence to the patient. However, the more accurate

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

these claims are, the more anxiety the patient feels, and what rises within the patient is not "the will to abstain from alcohol", but "the will to drink". The only way to increase the "will to abstain from alcohol" is for the patient to thoroughly understand the disease of addiction. If the doctor can convey to the patient not only the process of the formation of addiction (Table 1), but also the essence and horror of the disease, such as "one cannot define oneself without depending on someone else", "intoxication is a painkiller when this is not possible", and "eventually everyone will inevitably be treated as a liar by those around them", then the will to abstinence will surely be fostered.

IX. Do Not Raise the Intention to Drink

The question is, "Where does the will to drink lie?" It is not inside the patient, but outside. In addiction treatment, the factors that arouse craving are called "triggers." As with the aforementioned space travel story, if the patient is placed in a situation where they "absolutely cannot drink", their drinking intention will not increase. Therefore, the goal of treatment here is not to "create a craving-proof self", but to "continue to create an environment where cravings are unlikely to occur". Next, the specific treatment for "not raising the intention to drink" is introduced (Tables 2, 3, and 4).

The patient brings a "one-line diary", a diary of their drinking, to each visit, and the attending physician checks the contents of the diary and the patient's compliance (○, △) with "my rules" set by the patient based on "THE and TPO". When a slip is noted (X), rather than scolding the patient, the attending physician praises the fact that the patient was able to note the slip, reviews the "My Rules", and confirms the patient's willingness to be treated. When a patient slips, many family members make a fuss as if cancer has recurred. However, the essence of the problem is that "the patient's drinking does not stop after the slip", and even if the patient slips, if the patient is able to report it to their doctor and family at the right time, it does not mean that the treatment has failed. And if the one-line diary has been interrupted, it is necessary to conduct another round of disease education to raise the patient's "will to be abstinent" and lead them to resume abstinence.

Conclusion

Finally, I would like to conclude this paper by expressing my opinion on harm reduction in this disease. In the treatment of drug dependence, the term "harm reduction" is used 2). For example, in response to the current situation in which "HIV infection spreads among methamphetamine-

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

dependent patients because they share syringes", the government provides free and clean syringes in toilets and other places in downtown areas from the perspective of "Reducing the use of stimulants is difficult right now, but HIV transmission can be easily reduced if syringes are not reused". This may sound preposterous to the uninitiated, but it is already in use in Europe as an effective measure. What would happen if we were to translate this to alcohol? Calling the so-called "reduction of alcohol consumption" "harm reduction" gives a somewhat different impression. This is because harm reduction is a second-best measure that is considered when the amount of the substance used cannot be reduced. When we say "what is the next best thing" in alcoholism, isn't it "suicide prevention"? The relationship between suicide and alcohol is well known to all psychiatrists. It has been reported that not only the onset of depression secondary to alcohol, but also intoxication can ease fears and cause people to perform actions that they would normally be too afraid to take 1). On the other hand, the treatment of alcoholism is truly difficult. Physicians run the risk of hating the person that results in "healer helplessness" if the patient's alcohol intake never changes. And if they feel overwhelmed by this negative emotion, they may make a good argument and recommend a hospital transfer or hospitalization. However, from this perspective of harm reduction, physicians may be willing to let go of their sense of responsibility a little. Even if the patient's alcohol consumption does not decrease, if the therapist can continue to see the patient frequently and supportively by relaxing their shoulders, and if the patient's suicide is prevented, it is not second best, but rather one of the best.

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

References

1) 張 賢徳: 人はなぜ自殺するのか—心理学的剖検調査から見えてくるもの—. 勉誠出版, 東京, 2006

2) 松本俊彦: ハーム・リダクションの理念とわが国における可能性と課題. 精神経誌, 121 (12); 914-925, 2019

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

Table 1: Formative process of alcoholism, treatment

Pharmacology of alcohol, pathology and progression of alcoholism, and physical complications
(1) When a person consumes a small amount of alcohol, dopamine is released and the person feels a sense of relief from fatigue, or the function that controls the brain's ability to reason is suppressed and the person makes off-the-wall comments (disinhibition). (2) Continued frequent drinking increases the amount of alcohol required for disinhibition due to the body's adaptive response, resulting in hangovers, drunkenness, and alcohol-related failures (tolerance and dependence formation). (3) Continued drinking leads to the emergence of psychological dependence (craving for alcohol, exploratory behavior, and alcohol-centered thinking) and physical dependence (withdrawal symptoms such as insomnia and tremors) (the early stage of dependence). (4) When psychological dependence and physical dependence develop, the patient is unable to control the amount and timing of alcohol consumption, resulting in an increase in failure. The patient is instructed by others to refrain from drinking (early to middle stage of dependence). (5) Withdrawal symptoms such as strong anxiety, decreased motivation, and tremors accompanying a decrease in the body's concentration of alcohol appear, and drinking at inappropriate times becomes uncontrollable (middle to late-stage of dependence). (6) Finally, the patient loses interest in all things other than drinking (work, family, friends, etc.) and becomes socially isolated. Hepatic disorder, pancreatitis, and malnutrition are also complications, leading to death (late stage of addiction).
To increase the understanding and motivation for treatment, psychosocial treatment and drug therapy should be explained.
･Intoxication provides a temporary sense of refreshment and relief, but may cause loss of motivation and time to cope with stressors. In the future, discuss not only the amount of alcohol consumption, but also stressors and countermeasures. Specialized treatments such as cognitive-behavioral therapy and family therapy are also effective. ･The goal of treatment is to establish and maintain abstinence. In addition, when abstaining from alcohol in the current situation, medication such as anti-anxiety and sleeping pills should be used in conjunction with abstinence treatment due to the risk of withdrawal symptoms. ･Many people are reluctant to take the plunge into abstinence because it involves a strong decision. In addition, patients may be reluctant to come to our clinic if they relapse to alcoholism. For this reason, our clinic offers treatment methods such as "start by recording the amount of alcohol consumed" and drugs to support alcohol reduction.

Table 2 Organize your "triggers" by THE･TPO

T	Tools	Leftover alcohol, cash, beer glass
H	Human	Mr. ○○, Mr. △△, being alone
E	Emotion	Frustration, hunger, boredom, loneliness
T	Time	Coming home from work, Sunday noon
P	Place	Liquor corner of convenience store, chain noodle shops, weddings and funerals
O	Other	TV commercials, non-alcoholic beer

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author

Table 3: Creating My Rules

My rules
(1) I don't drink non-alcoholic beer (because I want to drink more real beer)
(2) Go to the gym in the morning on holidays (because I drink if I don't have plans on my day off)
(3) When eating out, go to restaurants that do not have alcohol (If I have no choice, I drink cyanamide)
Write down your own rules referring to the triggers in Table 2. Ask them to write down the reasons for their rules.

Table 4 One-line diary

10/1	I gave a presentation in front of the board of directors for the first time in my company and I was nervous.	○
10/2	I cleaned up my room and took out all the garbage (I skipped going to the gym)	△
10/3	I went to Shinjuku to see a movie I was looking forward to seeing. However, it was disappointing.	○★
10/4	I had to work overtime because I couldn't teach the new staff well. (On the way home, I bought a bottle of beer at a convenience store and drank it.)	×

Write down the most memorable event on a line every day. Finally, evaluate the drinking (○ no problem, △ broke a rule, × slipped, ★ developed a craving for alcohol), and if △ or ×, also write down the details. If the patient notes an × or more than three △'s, they should immediately seek medical attention from their primary care physician.

Copyright: ©The Japanese Society of Psychiatry and Neurology and Author