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National Alcohol Awareness Day 2005

A year ago Jeff Battista, Technical Director of the National Alcohol Awareness Day (NAAD, www.naad.org.uk), outlined in this publication (*Alcoholis* 2006;25(1)) the aims and results of the MCA's new venture held in November 2005. This issue of the bulletin is dedicated to the individual reports of the winners who were fortunate enough to be awarded one of the four placements. I believe that all who read these reports will be impressed by their standard and will appreciate the efforts of the authors in writing about their first experience of exposure to addicted patients. What has been equally impressive has been the alacrity and enthusiasm shown by the hosts in accepting these UK students, many of whom were fed and watered for free. The desire to repeat this process is strong and I wish to express the MCA's gratitude to all involved who made this project so successful. Copies of this issue will be sent to our sponsors – the Alcohol Education and Research Council and the Garfield Weston Foundation – to the deans of the four respective medical schools, and to the respective hosts. The proposal is to hold another NAAD in November 2007 with more possible placements available for the winners.

Naltrexone in alcohol dependence

More than one entry in last year's MCA Students' Essay prize included the possible use of naltrexone to reduce the craving for alcohol. It is worth emphasising that there is presently no licence in the UK for the use of this drug for this clinical indication although it is licensed in the USA and in some European countries.

Dr GE Ratcliffe, Editor

Reports from National Alcohol Awareness Day

Vienna

Alvin Karsandas, University of Newcastle upon Tyne

As one of the NAAD winners, I had the privilege of working alongside the internationally recognised alcoholism expert Professor Otto Lesch (pictured with Alvin) on a three week placement in Vienna, Austria. Professor Lesch and his team have carried out a large amount of research into alcoholism, potential causes and possible treatments. The Lesch Typology, devised by Professor Lesch himself, is used to categorise patients

with alcohol dependence into four subgroups: type I patients have a 'biological addiction' with early and severe withdrawals; type II patients use alcohol as a coping strategy; type III patients are a group with comorbidity, mainly depression, who use alcohol as an antidepressant;

continued overleaf

and type IV patients suffer from cognitive impairment prior to the development of alcoholism. Patients in each subgroup have different reasons for developing their addiction, suffer from different withdrawal syndromes, receive a different prognosis, and therefore benefit from different therapeutic approaches.

My placement was based at the Vienna General Hospital, known as the Allgemeines Krankenhaus Wien (AKH). Opened in 1994, the hospital also functions as a university medical centre and as Austria's largest medical research facility. With a floor area of approximately 338,000 m^2 and with over 5,000 members of staff, including 2,900 academic staff and physicians, the AKH is also Europe's largest hospital.

I was based in the psychiatric department in station 4A, a ward especially for alcoholic patients. I took part in the ward rounds each morning and followed a number of patients during their rehabilitation over the three-week placement.

I was able to spend time on other wards and in other departments both in the psychiatry unit and in the main hospital. I observed psychodynamic testing in which patients have to complete a series of tests relating to memory, concentration and ability to carry out simple arithmetic.

Different therapies are also offered to AKH patients. These include group therapy, music therapy and 'ergotherapy' in which patients are able to do art and craft work each day for up to 90 minutes. Depending on their illness, patients are assigned different crafts. For example, patients whose lives lack structure are encouraged to do weaving, a very structured type of artwork while those who find it difficult to concentrate are encouraged to work with clay, an activity which requires a lot of concentration.

On several occasions, I was fortunate enough to visit other centres within Vienna. One such visit was to a general practice medical centre where one of the doctors with a special interest in diabetes was conducting research, together with Professor Lesch, to see if a link exists between diabetes, depression and alcoholism. Another visit was to a centre for drug addiction where people who were abusing hard drugs, such as cocaine and heroin, received treatment. As well as being a place where patients could obtain methadone substitution therapy, the centre specialised in acupuncture.

My final visit was to a hospital known as Baumgartner Höhe, in west Vienna. The hospital is split up into 30 mini pavilions each with its own specialty. Although most of the pavilions were for psychiatry, there were some for neurology and general medicine. The pavilion which I visited was for patients who had freed themselves from alcohol addiction and were referred to the centre in order to rebuild their life, get a job and learn to live independently. All patients on this ward were voluntary admissions.

My placement in Austria was a great experience and it provided a huge insight into alcoholism, its potential causes and possible treatments. I am very grateful to Professor Lesch and his team for taking the time to teach me and also for organising and making my placement very worthwhile.

Montreal

Kheng Chiew Chooi, University of Glasgow

I spent a total of four weeks assigned to the Montreal General Hospital based at two sites, the 4 East Psychiatric Ward and the Griffith Edwards House where the day programme activities are held.

At the psychiatric ward, I was part of the team who cared for the patients with addictions. We did admission interviews, assessments, and managed their care on a day-to-day basis. We held weekly meetings with the whole team and the patients to discuss their progress as well as their management for the coming week and any other issues. The patients had ample opportunities to air their views, including those about, for example, their proposed next phase of treatment. This was my first clinical experience, and it was interesting to learn from patients first hand. Dealing with psychiatric patients was also an engaging experience.

Besides caring for inpatients, I also worked with the outpatients and their addiction management. The hospital runs an outpatient day programme focusing on group therapy and open discussions about their lives, with a special focus on their problems with, and experiences of, addictions. There are also patient education sessions and yoga lessons. The patients have a private therapist who gives them one-to-one attention if requested.

In addition to learning about addictions, I had the opportunity to be exposed to other spheres of psychiatry including observing electroconvulsive therapy being performed on chronic schizophrenia patients. I also went on-call at the emergency psychiatry department and saw a few interesting cases. My supervisor discussed some of the cases with me at length as well as treatments I did not get to observe, for instance, psychoanalysis. I was also able to observe assessments for inclusion into the Borderline Personality Disorder Clinic and attend classes and teaching-learning sessions with other McGill University medical students and residents.

Overall, it was a very fulfilling experience. The doctors did their best to help me feel at home and to learn and experience as much as I could. The arrangements that were made were excellent, and I appreciate all that the MCA has done to make this possible for me. I am particularly grateful to Dr Jorge Palacios-Boix, Medical Director, Addictions Unit, McGill University Health Centre for coordinating my arrangements in Montreal.

Castle Craig

Adele Tinsley,
University of East Anglia

It is difficult to describe my time at Castle Craig, Scotland, as it was an invaluable placement which I recommend should be experienced. I feel extremely privileged to have met the people I did, become involved, and gain such a deep insight into addiction. I also gained a new perspective on alcohol dependence, one I had not been able to appreciate before my placement, one of hope.

I thought I was quite well read about addiction before my placement. But I now realise that there is still so much to learn and I am humbled by my previous complete lack of understanding of what recovery entails. During my previous placements in primary care, there seemed to be this black hole, where anyone with alcohol dependence was recommended to go to an Alcoholics Anonymous (AA) meeting or referred to a specialist. I also had my doubts: how can you cure alcoholism? If someone is drinking as an escape from a hard life, this is not something a doctor can fix. I was familiar with the concept of addiction as a disease, but also appreciated that unfortunately there was no magic pill. It was only when attending a meeting myself during my stay at Castle Craig that I started to work out what it was all about.

At my first AA meeting I was introduced to the twelve steps, and an initially scary rendition of the Serenity Prayer:

God, grant me the serenity
To accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.

I consider myself to be of an open-

An introduction to Alcoholics Anonymous

Alcoholics Anonymous (AA) is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; they are self-supporting through their own contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Their primary purpose is to stay sober and help other alcoholics to achieve sobriety.

© AA Grapevine Inc

In simplest form, the AA program operates when a recovered alcoholic passes along the story of his or her own problem drinking, describes the sobriety he or she has found in AA, and invites the newcomer to join the informal Fellowship. The relative success of the AA program seems to be due to the fact that an alcoholic who no longer drinks has an exceptional faculty for 'reaching' and helping an uncontrolled drinker. The heart of the suggested program of personal recovery is contained in Twelve Steps describing the experience of the earliest members of the Society. Newcomers are not asked to accept or follow these Twelve Steps in their entirety if they feel unwilling or unable to do so. They will usually be asked to keep an open mind, to attend meetings at which recovered alcoholics describe their personal experiences in achieving sobriety, and to read AA literature describing and interpreting the AA program. AA members will usually emphasize to newcomers that only problem drinkers themselves, individually, can determine whether or not they are in fact alcoholics. At the same time, it will be pointed out that all available medical testimony indicates that alcoholism is a progressive illness, that it cannot be cured in the ordinary sense of the term, but that it can be arrested through total abstinence from alcohol in any form.

Bill W, one of the founders of AA emphasized that 'alcoholism was a malady of mind, emotions and body'. This all-important fact he had learned from Dr. William D. Silkworth of Towns Hospital in New York, where Bill had often been a patient.

The Recovery Program, www.aa.org

Why Anonymous?

In the early days of AA, when more stigma was attached to the term 'alcoholic' than is the case today, this reluctance to be identified, and publicised, was easy to understand. As the Fellowship of AA grew, the positive values of anonymity soon became apparent. First, they knew from experience that many problem drinkers might hesitate to turn to AA. for help if they thought their problem might be discussed publicly, even inadvertently, by others. Newcomers should be able to seek help with complete assurance that their identities will not be disclosed to anyone outside the Fellowship. Then, too, they believe that the concept of personal anonymity has a spiritual significance for them; that it discourages the drives for personal recognition, power, prestige, or profit that have caused difficulties in some societies. Much of their relative effectiveness in working with alcoholics might be impaired if they sought or accepted public recognition.

www.alcoholics-anonymous.org.uk

minded-yet-uncommitted-scientific-type religious holding, albeit a little unsure of how comfortable I felt with the profuse use of the word 'God'. This eventually, and thankfully, was explained to me as meaning 'referring to a power greater than yourself' – similar to the twelve steps with the group holding hands in a circle, more group cuddle than cult. Working past the initial shock to the system, it was only towards the end of my stay, I actually appreciated what I was saying. I interpreted it as finding inner peace with yourself and life. One person put it to me that 'life may be hard, but it is what you make of it, and it certainly isn't going to get any better with an addiction in tow'. I understand now that treatment, like the disease, consists of many different facets, self reflection, acquisition of life skills and direction, education about the disease and the addiction process, support and the sharing of experiences, to mention but a few, working towards the unified goal of sobriety.

Being a patient enabled me to experience a truly unique rehabilitation process as, by crossing the boundaries between patient and doctor, I came to realise that I was no different to anybody else. I thought I had come equipped with no preconceived ideas or stigma, although at the same time why did I assume that I was different to anybody else? Being a medical student, if anything, puts me at a higher risk of addiction, a fact that I'm sure many in the medical profession may overlook in their roles.

Castle Craig, Peeblesshire, Scotland

That being so, I clearly was not an 'addict', albeit at the end of one session I had convinced myself, and everybody around me for that matter, that I had an unhealthy relationship with coffee and chocolate. Compounded by a lecture earlier in the day addressing cross addiction, I wasn't feeling as virtuous as I would have liked. I guess this is one of the issues that played on my mind, one of vulnerability. Addiction is an indiscriminate disease, blind to gender, age, profession, social class and culture. We all appreciate, and may gain some peace of mind, from certain associations that are recognised, but I feel this may breed a certain amount of complacency and comfortable denial that exists in all of us that it won't happen to me.

Sitting in with the members of staff enabled me to explore the complexities of counselling and the therapeutic process I had been subject too. I was in awe while observing the staff discussions of group sessions, the deeper meanings and interpretations drawn from what I had seen as some throwaway comments. It was only through reflection upon lectures I had attended that I began to understand the level of skill required in seeing through the masks and defences, unravelling honesty and denial, and ascertaining human powerlessness – and that was only step one.

One poignant aspect of the therapeutic process was personifying the founding principles of AA; that the majority of the therapists are recovered/recovering addicts. I express that with separate tenses after being fortunate enough to attend 'outside' meetings with therapists, I became aware of the set introduction of 'hello, I'm X, and I'm an addict'. Yet again, I only later recognised the connection to the 'just for today' ethos discussed in Narcotics Anonymous; combining the already proven formula of shared experiences and perspective with the counselling skills of interpreting, and in turn relating to, people.

There are many other thoughts and memories I cherish from my stay. All of the staff and patients were welcoming far beyond my expectations, easing my nerves, making me feel involved and supporting me along the way. One encounter from my placement always makes me smile, something to do with some kind of open innocence of the situation. While chatting to a patient, while I was a patient, I described my day-to-day life as a medical student, and then asked him what he did. He replied 'cocaine and alcohol', although it eventually turned out to be painting and decorating.

Seattle

Jennifer Hague,
University College, London

I was fortunate enough to be awarded a placement to study alcohol and other substance abuse therapy at the Center of Excellence in Substance Abuse, Treatment and Education (CESATE) at the Veteran's Affairs Medical Center in Seattle, USA. The hospital treated patients who were, or had been, members of the American Armed Forces, and who would usually receive free government healthcare. The patients I met had chiefly seen action in the Vietnam, Korean or Gulf wars although some had recently served in Iraq.

The patients I worked with were all male and were being treated for substance addiction, most commonly alcohol but also for addiction to crack cocaine, heroin, amphetamines, cannabis and even cough syrup abuse. They were admitted as inpatients for a week, under a regime of acute withdrawal. The patients were medically assessed for other clinical problems, then monitored and given multi-vitamins as well as benzodiazepines (Librium) if their withdrawal symptoms were extreme. They were often started on treatments

such as Antabuse and naltrexone. After one week they attended the ward daily as outpatients. The patients were typically homeless and living in temporary shelters, often a sad result of their addiction. Prior to their illness most patients had jobs, homes and families, and, as one patient, an ex-bus driver, phrased it, these 'evaporated' after his addiction to crack cocaine took hold.

All patients were initially put on intensification stabilisation therapy. This programme involved two group therapy sessions a day plus individual meetings with a counsellor; other group sessions covered topics such as anger management and self esteem. The therapy sessions included working through personal exercises and sharing them with the group, as well as education such as videos on addiction, team exercises and discussions on personal experiences. These sessions were both educational and extremely moving as many personal histories included extremely traumatic experiences both in home life and during their military service. Many patients had dual diagnoses, ie substance addiction as well as another psychiatric disorder, for example bipolar or personality disorder. The aim of the medical staff was to treat the addiction first, then tackle the underlying psychiatric condition, but I was informed by the staff that sadly, the patients with dual diagnoses responded less well to treatment.

My placement also included work with outpatients who had completed intensification stabilisation and had less intensive (twice weekly) group therapy sessions which lasted for six months from the start of treatment. As well as observing the addiction programme, I attended seminars, teaching sessions and presentations on a range of psychiatric conditions. I was given the opportunity to attend an Alcoholics Anonymous meeting and also visited another addiction treatment centre in the Seattle area, which catered for teenagers and adults.

My knowledge has been enhanced by my placement both from the inspiring patients, and the friendly and knowledgeable staff. It taught me to appreciate that there is not a 'typical addict' and that people from many different backgrounds can become addicted to substances for a variety of reasons. I also learned to appreciate that success for addiction therapy professionals is often measured differently from the medical opinion that 'cure' is the goal. Patients at best would only learn to manage their addiction, and unfortunately this would be a lifelong battle. Often, success was measured by a patient being sober for a longer period of time than before, or by fewer binges after therapy. Usually patients had been in detox many times before. Some patients, however did eventually succeed in staying sober, after several attempts to do so. The medical staff were realistic in their expectations of their patients, and had a pragmatic and non-judgmental attitude to relapse.

I thoroughly enjoyed my time in Seattle and would especially like to thank Dr Rioux and Dr Kivlahan for allowing me to experience their work at the centre. I would also like to thank the MCA for allowing me to experience addiction therapy in another country, it was a very enjoyable and worthwhile experience.

MCA MCQs

1. True or False

A ☐ Chronic asymptomatic HbsAg carriers are more susceptible to alcohol induced liver injury.

B ☐ Alcohol consumption is the single most relevant factor in the development of hepatocellular carcinoma in some Western countries.

C ☐ Interaction between Hepatitis A and alcohol has not been reported.

D ☐ Serum levels of HBV and HCV load are not significantly higher in alcoholics.

E ☐ The development of hepatocellular carcinoma in HbsAg positive patients may be foreshortened by up to ten years in patients who consume alcohol.

2. Acute alcoholic myopathy – True or False

A ☐ Usually occurs in male alcoholics between 40 and 60 years.

B ☐ May be subclinical.

C ☐ Does not commonly affect the girdle muscles.

D ☐ Muscle tenderness is rare.

E ☐ Blood muscle enzymes usually increase 2–10 fold.

3. True or False

A ☐ Oral and intragastric ethanol administration increases pancreatic bicarbonate and protein secretion.

B ☐ Non-alcoholic constituents of beer do not affect pancreatic secretion.

C ☐ In alcoholics the pancreatic bicarbonate secretion is decreased.

D ☐ Nutritional factors contribute to the development of alcoholic chronic pancreatitis.

E ☐ Alcohol administered selectively reduces pancreatic blood flow and microcirculation.

Answers on back page

MCA MCQ answers

1. **A** True, **B** True, **C** True, **D** False, **E** True.
2. **A** True, **B** True, **C** False, **D** True, **E** True
3. **A** True, **B** False, **C** True, **D** True, **E** True.

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Berlin 2007

23–26 September

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Applications to: contact@esbra2007.com.

MCA dates for your diary 2007

14 March	Executive Committee
16 May	Education Committee
5 June	Journal Committee

Alcoholis

Publication dates

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