CAMBRIDGE

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

Section 1 Background to understanding

© in this web service Cambridge University Press www.cambridge.org

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

Section 1
Chapter 1

Background to understanding

Definitions of drinking problems

What is a 'drinking problem'?

The treatment of 'drinking problems', at first blush, may seem to be a frustratingly vague topic for a book. It doesn't define the problem in terms of a particular treatment setting or by a particular amount or pattern of alcohol consumption; nor does it equate the problem with the criteria of any particular diagnostic system. Rather it is a common-sense, broad-brush description grounding the issue in actual drinking behaviour that causes problems. Such drinking problems may be perceived differently by the individual, their social network, family and society at large, even to the point that what some consider a problem others consider to be of no concern at all. However, within this melting pot of behaviours there is a semblance of structure, related to the multiple domains that map onto the specific classifications of alcohol problems, which provides a means of communication, signposts treatment, indicates prognosis and forms the basis for research.

The many faces of drinking problems

To many workers in the field, including readers of prior editions of this volume, the phrase 'drinking problem' conjures up thoughts of cases like this one.

> Robert is a 45-year-old unemployed white male who was admitted to the in-patient alcohol unit for medically assisted withdrawal from alcohol for the second time in 1 year. He began drinking heavily in his teens, with only a few months of abstinence since, all of them stimulated by short-term contacts with treatment professionals and Alcoholics Anonymous, none of which resulted in lasting change. His wife became fed up with his drinking 5 years ago and kicked him out of the house, and he has lived in shelters, halfway houses, single-room occupancy hotels and other marginal housing arrangements since, including periods when he slept under a bridge with his 'bottle gang'. In morning group on the ward, his hands shake as he holds his cup of tea and tells his doctor and fellow patients in a trembling voice that 'this time, I'm really going to make a go of it'.

Individuals with severe alcohol dependence seen in specialist care settings, such as Robert, are familiar to anyone who works in the alcohol field, and remain a major focus of this edition of this book. Yet drinking problems occur and present across all social structures and health resources, and are not neatly confined within the specialist addiction sector. This text, professing to address the treatment of drinking problems, considers the whole range of approaches: from informal through non-specialist to specialist services. As such it does not merely comment on the treatment of established alcohol dependence but also examines interventions that may reverse, prevent or delay the progression of alcohol problems. This brings cases like the following into the ambit of this volume.

© in this web service Cambridge University Press www.cambridge.org

Cambridge
Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

Michael is a 50-year-old successful salesman of Indian descent. He is slightly overweight and is being monitored regularly by his primary care physician for elevated blood pressure. His doctor is mystified by the difficulty they experience in bringing Michael's blood pressure under control; the medications and diet recommendations do not seem to be working. During an early afternoon appointment, the doctor notices that Michael seems slightly tipsy and asks if he has been drinking. Michael smiles and says: 'Of course, a three martini lunch with clients is standard practice in the sales game. But it's not like I'm an alcoholic or anything: I've got a job, a house, a great family and I'm a star performer at my firm. So, on the blood pressure, are you going to switch my medication or what?'

Emily is a 22-year-old honours college student whose roommate brings her to the Accident and Emergency Department (Emergency Room) at midnight on a Saturday for treatment of facial bruising and a cracked tooth. Emily had been assaulted by her boyfriend, who was convinced that she had been flirting with the barman. Emily's boyfriend goes on pub crawls many times during the week; she accompanies him only on weekends. Her boyfriend is under arrest and Emily is sobbing hysterically that she doesn't want him in jail. With slurred words, she protests: 'He's not really like that – it's the drink that makes him act that way. I've been after him to cut back'. Emily attempts to leave as soon as her injuries are treated, but the doctor asks her to wait a moment so that the alcohol liaison nurse can have a word with her. 'About my boyfriend's drinking?' Emily asks. 'No', says the doctor kindly, 'about yours'.

George was a hard-working, well-respected judge before he retired at 65 years of age; in fact his wife described him as having a tendency to be a bit of a 'workaholic'. On retirement he had experienced long periods of boredom, something he had rarely felt before, and consequently he spent more time practising his hobby of wine tasting. One Monday, after a particularly indulgent weekend, shortly after entering a wine bar with his wife, he experienced an episode of loss of consciousness, bit his tongue and was incontinent of urine. Believing that George had suffered a stroke, his wife telephoned an ambulance which took George to hospital, where he was admitted to the clinical decision unit overnight and next day transferred to a neurology ward for further investigation. Two days later, he started to become confused and suspicious, and during an MRI scan leapt off the trolley, pulling out his intravenous line. 'That machine is trying to read my mind!' he yelled, maintaining that the stolen personal information would be used by the criminal fraternity to destroy his family in a final act of revenge. He was restrained by the hospital security team and following a short period of sedation with benzodiazepines he recovered, but still finds it difficult to understand this frightening period in his life.

A population perspective on drinking

Drinking within a population can be envisaged as a continuous spectrum ranging from non-drinkers, through 'sensible drinkers', to those described in the examples above: 'hazardous drinkers', 'harmful drinkers' and 'dependent drinkers'. The proportion of any given population in these categories varies, with both alcohol availability and acceptability being important determinants.

Sensible drinking or 'normal drinking'

Quantity/frequency definitions

In the UK the drinking guidelines formulated by the Royal Colleges of Physicians, Psychiatrists and General Practitioners converged in the mid-1980s to define low-risk drinking as being less than 21 units of alcohol per week for men and less than 14 units per week for women (1 unit = 8 g alcohol) (British Medical Association, 1995). Consumption of 22–50 units per week

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

for men and 15–35 units per week for women was considered as hazardous, and consumption of over 50 units per week for men and 35 units per week for women as harmful. In 1995, the Department of Health moved from weekly to daily limits, and advised that 'regular consumption of between 3 and 4 units a day by men of all ages will not accrue significant health risk' (Department of Health, 1995, p. 32). Likewise women were advised that 'regular consumption of between 2 and 3 units a day by women of all ages will not accrue any significant health risk' (Department of Health, 1995, p. 32). These guidelines, based on epidemiological data of alcohol-related morbidity and mortality, are similar to those available in other countries (Tables 1.1 & 1.2).

For instance, US guidelines advise that 'those who choose to drink alcoholic beverages should do so sensibly and in moderation – defined as the consumption of up to one drink per day for women and up to two drinks per day for men' [an American standard drink contains 14 g of ethanol] (US Department of Health and Human Services and US Department of Agriculture, 2005, p. 44). Recently the Australian National Health and Research Council recommended that neither men nor women should exceed 2 standard drinks per day (1 standard drink = 10 g) (National Health and Medical Research Council, 2007).

'At risk' drinking is commonplace and young drinkers are particularly prone to drinking in this fashion. Using data from the National Longitudinal Alcohol Epidemiologic Survey, Dawson and colleagues calculated that a third of drinkers never exceed moderate alcohol consumption, a third do so occasionally and for the rest it was their usual behaviour (Dawson, Archer & Grant, 1996). Furthermore, 88% of the alcohol was consumed in a risky fashion. Similarly, in the UK, the General Household Survey for 2006 reported that 40% of men and 33% of women had exceeded daily sensible limits in the preceding week (Goddard, 2008). In Australia, data from the 2007 National Drug Strategy Household Survey revealed that some 24% of males and 17% of females reported drinking more than the recommended guidelines for acute harm on at least one occasion a month (more than 6 standard drinks for men and 4 for women), and 10% drank in excess of guidelines for chronic alcohol-caused problems (more than 4 standard drinks for men and 2 for women on an average day) (Australian Institute of Health and Welfare, 2008). Previous analysis from these surveys indicate that 62% of the alcohol consumed was at

Table 1.1. Example of standard drink sizes in different countries.

Country	Standard drink (grams of ethanol)
UK	8
Ireland	10
The Netherlands	9.9
Australia	10
New Zealand	10
France	10
Italy	12
South Africa	12
Canada	13.6
USA	14
Japan	19.75

Source: http://www.icap.org/table/InternationalDrinkingGuidelines.

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

Table 1.2. Examples of recommended drinking limits for drinking in different countries (grams of ethanol).

Country	Men	Women
Australia	20 g/day	20 g/day
New Zealand	30 g/day or 210 g/week	20 g/day or 140 g/week
UK	24–32 g/day or 168 g/week	16–24 g/day or 112 g/week
France	30 g/day	30 g
The Netherlands	39.6 g/day	19.8 g/day
USA	14–28 g/day; 196 g/week	14 g/day; 98 g/week
Canada	27.2 g/day; 190 g/week	27.2 g/day; 122 g/week

Source: http://www.icap.org/table/InternationalDrinkingGuidelines.

a risky/high-risk level for acute harm, and this was particularly pronounced in the 14–17 and 18–24-year age groups in which this accounted for more than 80% of the alcohol consumed (Chikritzhs et al., 2003). Similarly, in the UK between 63% and 75% of alcohol is consumed in a non-sensible manner, particularly by younger adults (Williamson, 2007).

Categories of alcohol misuse: alcohol use disorders

Three categories of alcohol misuse make up the top three tiers of the pyramid in Figure 1.1, namely hazardous drinking, harmful drinking and alcohol dependence (Edwards, Arif & Hodgson, 1981). Hazardous drinking refers to drinking that has not yet accrued any harm, but exceeds sensible and safe limits. Harmful drinking describes drinking behaviour that incurs harm. The division between these two is somewhat arbitrary and dependent on the ability to detect harm. For example, the use of markers sensitive to alcohol-related liver damage could shift those previously oblivious of this harm into the harmful category. Finally the development of symptoms suggestive of dependence indicates the diagnosis of alcohol dependence.

Hazardous drinking

Hazardous drinking refers to drinking above a certain limit that places the individual at risk of incurring harm. It was described by Edwards and colleagues in a World Health Organization (WHO) report as:

> Use of a drug that will probably lead to harmful consequences for the user – either to dysfunction or to harm. This concept is similar to the idea of risky behaviour. For instance, smoking 20 cigarettes each day may not be accompanied by any present or actual harm but we know it to be hazardous (Edwards, Arif & Hodgson, 1981, p. 228).

The WHO *Lexicon of Alcohol and Drug Terms* described hazardous use of a substance as:

> A pattern of substance use that increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by WHO but is not a diagnostic term in ICD-10 (World Health Organization, 2010).

Hazardous drinking usually applies to anyone drinking over the recommended levels. One common pattern of hazardous use is 'binge drinking'; for example, defined as drinking in

© in this web service Cambridge University Press www.cambridge.org

Cambridge

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

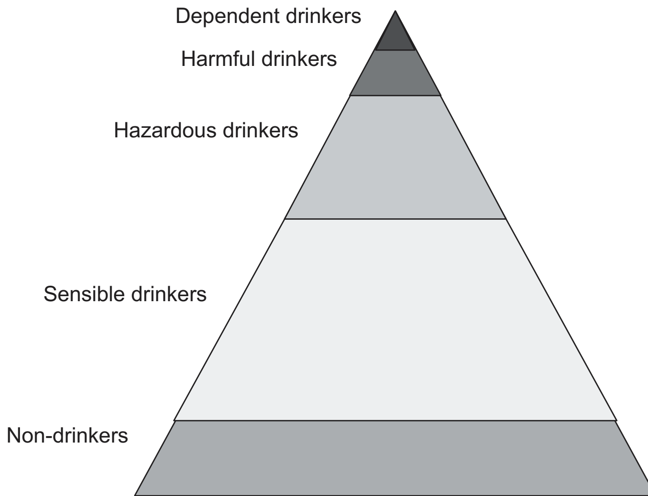

Figure 1.1. Drinking within the population. The areas are not accurate representations of the relative proportions of those exhibiting differing drinking behaviours as this varies between populations.

excess of 8 units per day for men and 6 units per day (or in one episode) for women. Binge drinkers are at risk of harm, even though they may not exceed the 'safe' weekly limits. Binge drinking is not represented in Figure 1.1 or in the diagnostic criteria, because it is not specific to any level of consumption: hazardous, harmful and dependent drinkers may all have drinking binges. The term and its synonyms (e.g. bouts, benders) have no firm definition in everyday speech or in clinical practice.

Hazardous drinkers do not usually seek help for an alcohol problem. They are typically picked up opportunistically in the primary care or general hospital setting.

Harmful drinking

Harmful psychoactive substance use was described by Edwards and colleagues in their 1981 WHO report as 'use of a drug that is known to have caused tissue damage or mental illness in the particular person' (Edwards, Arif & Hodgson 1981, p. 228). Unlike hazardous drinking, harmful use is a diagnostic term within the International Classification of Diseases (ICD-10) where it is defined as:

> A pattern of psychoactive substance use [in this case alcohol] that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. depressive episodes secondary to heavy consumption of alcohol) (World Health Organization, 1992, pp. 74–75).

Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use. The equivalent diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) is that of alcohol abuse (American Psychiatric Association, 2000). This is defined as a 'maladaptive pattern of substance use [in this case alcohol] leading to clinically significant impairment or distress' (American Psychiatric Association, 2000, p. 199). In the absence of a diagnosis of alcohol dependence, the criteria include at least one of the following alcohol-related recurrent behaviours: failure to fulfil major obligations; use in situations in which it is

© in this web service Cambridge University Press www.cambridge.org

Cambridge

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

physically hazardous; legal problems; continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

Harmful drinkers usually present to primary care, the general hospital, the criminal justice system and to Social Services.

Alcohol dependence (syndrome)

The tip of the pyramid in Figure 1.1 represents the dependent drinker. These individuals typically have a history of alcohol-related problems, and may present directly to alcohol services but often present to other services. Moderately dependent drinkers will show evidence of tolerance, alcohol withdrawal and impaired control over drinking. Severely dependent drinkers typically have long-standing problems and a history of repeated treatment episodes.

Based somewhat on the traditions imposed by different diagnostic systems, some scientific and clinical work on this population of drinkers has been organized under the concept of 'alcohol dependence' (e.g. studies using the DSM-IV-TR), whereas other work has been informed by the concept of the 'alcohol dependence syndrome' (e.g. studies using the ICD-10). Etymologically, the English word 'syndrome' derives from the Greek 'syn' meaning together and 'dromos' meaning running. Thus the 'alcohol dependence syndrome', as operationally defined by the ICD-10, is a collection of symptoms that 'run together' including a compulsion to take alcohol, difficulty with control, withdrawal symptoms and relief drinking, tolerance, predominance and persisting use despite evidence of harm. Nonetheless, the ICD-10, like the DSM-IV-TR, requires only three of the criteria to be present, and so perhaps the strict definition of syndrome, as 'consistently occurring together', should not apply to the ICD-10. The DSM-IV-TR criteria are similar and include tolerance, withdrawal symptoms, taking of alcohol in greater amounts than intended, desire or unsuccessful attempts to cut down, spending extensive time in activities to obtain alcohol or recover, giving up of activities and persistent use despite associated problems (Tables 1.3 & 1.4).

A mechanistic approach to the diagnosis of dependence is insufficient. Dependence cannot be conceived as 'not present' or 'present', with the diagnostic task then completed. The skill lies in being able to recognize the subtleties of symptomatology, which will reveal not only whether this condition is there at all but, if it exists, the degree of its development. What has also to be learnt is how the syndrome's manifestations are moulded by personality, by environmental influence or by cultural forces. It is the ability to comprehend the variations on the theme that constitute the real art. However, for those who wish to revisit diagnostic criteria these are presented in Tables 1.3 and 1.4. If the therapist cannot recognize *degrees* of dependence, they will not be able to fit their approach to the particular individual, and they may retreat into seeing 'addiction to alcohol' as a fixed entity from which all individuals with drinking problems are presumed to suffer, for whom the universal goal must be total abstinence and with the treatment which is offered universally intensive. The needed skill is the development of a discriminating judgement, which is able in each case to sense out the degree of dependence, identify a rational treatment goal with that person and propose a treatment plan fitted to their goal.

Clinical genesis of the concept

A syndrome is a descriptive clinical formulation which is, at least initially, likely to be agnostic as to causation or pathology. The existence of alcohol dependence has been evident to acute observers for many years (e.g. Thomas Trotter's essay of 1804), but in the 1970s a detailed clinical description was enunciated within a syndrome model (Edwards & Gross, 1976). It was suggested

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

Table 1.3. The DSM-IV-TR criteria for alcohol dependence.

A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring within a 12-month period.
1 Tolerance, as defined by either of the following:
(a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect;
(b) markedly diminished effect with continued use of the same amount of alcohol.
2 Withdrawal, as manifested by either of the following:
(a) the characteristic withdrawal syndrome for alcohol;
(b) the same (or a closely related) substance is taken to relieve or avoid alcohol withdrawal symptoms.
3 Alcohol is often taken in larger amounts over a longer period of time than was intended.
4 There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
5 A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
6 Important social, occupational or recreational activities are given up or reduced because of alcohol use.
7 Alcohol use is continued despite knowledge of having a persistent or recurring problem that is likely to have been caused or exacerbated by alcohol (e.g. continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Source: American Psychiatric Association (2000).

Table 1.4. The ICD-10 criteria for alcohol dependence syndrome.

A cluster of physiological, behavioural and cognitive phenomena in which the use of alcohol takes a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take alcohol. There may be evidence that the return to alcohol use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with non-dependent individuals.
Three or more of the following have been experienced or exhibited at some time in the previous year.
(a) Strong desire or sense of compulsion to take alcohol.
(b) Difficulties in controlling alcohol-taking behaviour in terms of its onset, termination or level of use.
(c) A physiological withdrawal state when alcohol use has ceased or has been reduced, as evidenced by: the characteristic withdrawal syndrome for alcohol; or use of the same (or a closely related substance) with the intention of relieving or avoiding withdrawal symptoms.
(d) Evidence of tolerance, such that increased dosages are required in order to achieve effects originally produced by lower dosages.
(e) Progressive neglect of alternative pleasures or interests because of alcohol use, increased amount of time necessary to obtain or take alcohol or recover from its effects.
(f) Persisting with alcohol use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to heavy substance misuse or alcohol-related impairment of cognitive functioning. Efforts should be made to determine if the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Source: World Health Organization (1992).

by Edwards and Gross that clinical observation revealed a repeated clustering of signs and symptoms in certain heavy drinkers. Further, it was postulated that the syndrome existed in degrees of severity rather than as a categorical absolute, that its presentation could be shaped by pathoplastic influences rather than its being concrete and invariable and that alcohol dependence should be conceptually distinguished from alcohol-related problems. This clinically derived

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

formulation was at that stage designated as only provisional, and within the general research tradition of psychiatric taxonomy the *validity* of the syndrome had then to be determined.

Alcohol dependence: establishing syndrome validity

Following the original description, research has tested multiple aspects of validity. The overall conclusion to be drawn from this, by now extensive body of research, is that the syndrome is a reality rather than a chimera of the clinical eye. That is not to say that all elements are in psychometric terms equally well tied into the syndrome. Within a psychometric perspective, some elements may be redundant, and difficulties have been encountered in operationalizing elements, such as narrowing of repertoire, subjective change and reinstatement.

Elements of the alcohol dependence syndrome

The elements of the syndrome as originally formulated by Edwards and Gross will now be discussed sequentially below rather than the more restrictive formulations described in ICD-10 or DSM-IV-TR (Edwards & Gross, 1976). The alcohol dependence syndrome is a hypothetical construct which formal diagnostic criteria index to some extent. However, it is important to appreciate that the symptoms of this hypothetical construct are not, strictly speaking, equivalent to a diagnostic symptom list.

Narrowing of repertoire

The ordinary drinker's consumption and choice of drink will vary from day to day and from week to week; they may have a beer at lunch on one day, nothing to drink on another, share a bottle of wine at dinner one night and then go to a party on a Saturday and have several drinks. Their drinking is patterned by varying internal cues and external circumstances.

At first, a person becoming caught up in heavy drinking may widen their repertoire and the range of cues that signal drinking. As dependence advances, the cues are increasingly related to relief or avoidance of alcohol withdrawal, and their personal drinking repertoire becomes increasingly narrowed. The dependent person begins to drink the same whether it is a workday, weekend or holiday; the nature of the company or their own mood makes less and less difference. Questioning may distinguish earlier and later stages of dependence by the degree to which the repertoire is narrowed. With advanced dependence, the drinking may become scheduled to a strict daily timetable to maintain a high blood alcohol. More careful questioning will, however, show that even when dependence is well established, some capacity for variation remains. The syndrome must be pictured as subtle and plastic rather than as something set hard, but as dependence advances the patterns tend to become increasingly fixed.

Salience of drinking

The stereotyping of the drinking pattern as dependence advances leads to the individual giving priority to maintaining their alcohol intake. The spouse's distressed scolding – once effective – is later neutralized by the drinker as evidence of a lack of understanding. Income, which previously had to serve many needs, now supports the drinking habit as the first demand. Gratification of the need for drink may become more important for the individual with liver damage than considerations of survival. Diagnostically, the progressive change in the salience given to alcohol is important, rather than the behaviour at any one time. The individual may relate that they used to be proud of their house but now the paint is peeling, used always to take the

© in this web service Cambridge University Press

CAMBRIDGE

Cambridge University Press
978-0-521-13237-4 - The Treatment of Drinking Problems: A Guide for the Helping Professions, Fifth Edition
E. Jane Marshall, Keith Humphreys and David M. Ball
Excerpt
More information

children to football matches but now spend no time with the family, used to have rather conventional moral standards but will now beg, borrow or steal to obtain money for alcohol.

Increased tolerance to alcohol

Alcohol is a drug to which the central nervous system (CNS) develops tolerance (see Chapter 2). Individuals themselves report on tolerance in terms of 'having a good head for liquor'. Clinically, tolerance is shown by the dependent person being able to sustain an alcohol intake and go about their business at blood alcohol levels that would incapacitate the non-tolerant drinker. This does not mean that their functioning is unimpaired – they will be a dangerous driver, but because of their tolerance they will (unfortunately) still be able to drive. Furthermore, an individual may present with very high blood alcohol concentrations that would be fatal for the non-tolerant, yet not appear intoxicated, engage in a constructive interview and even remember it afterwards! Acute tolerance, which any normal subject will experience in response to even a single dose of alcohol, needs to be distinguished from the chronic tolerance, which is a feature of the dependence syndrome.

Cross-tolerance will extend to certain other drugs, notably the sedative-hypnotics such as benzodiazepines, which means that the person who has become tolerant to alcohol will also have a tolerance to these drugs and vice versa. Indeed, this cross-tolerance can be exploited by using benzodiazepines to prevent and manage alcohol withdrawal symptoms during detoxification. The rate of development of tolerance is variable, but the heavy drinker who is not dependent can manifest tolerance. In later stages of dependence, for reasons that are unclear, the individual begins to lose their previously acquired tolerance and becomes incapacitated by quantities of alcohol which they could previously handle. They may begin to fall down drunk in the street.

Withdrawal symptoms

At first these symptoms are intermittent and mild; they cause little incapacity, and one symptom may be experienced without others. As dependence increases so does the frequency and severity of the withdrawal symptoms. When the picture is fully developed, the individual typically experiences severe multiple symptoms every morning on waking and perhaps even in the middle of the night. Questioning often reveals that the severely dependent individual experiences mild withdrawal symptoms (which they recognize as such) at any time during the day when their alcohol level falls. Complete withdrawal is therefore not necessary to precipitate disturbance.

The individual often remembers rather exactly the dating of the period when they first began to experience withdrawal, and there is no necessary association with a sudden increase in alcohol intake.

The spectrum of symptoms is wide and includes tremor, nausea, sweating, sensitivity to sound (hyperacusis), ringing in the ears (tinnitus), itching, muscle cramps, mood disturbance, sleep disturbance, hallucinations, generalized (*grand mal*) seizures and the fully developed picture of delirium tremens. There are four key symptoms, outlined below.

Tremor

This nicely illustrates that it is *degree* of symptom experience that is essential to the clinical observation, rather than a recording in the case notes simply that the individual does or does not experience withdrawal tremor. Shakiness may have been experienced only once or twice,

© in this web service Cambridge University Press www.cambridge.org