A Case of Alcohol Abuse

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The patient is a 65-year-old white woman, married for 35 years to an accountant. They have 5 grown children and 12 grandchildren. She taught elementary school for 28 years and has not worked since retiring 15 years ago. Her mother suffered with hypertension and died of a cerebrovascular accident 10 years ago at age 81. Her father died after a heart attack more than 30 years ago at age 55. She has 2 younger sisters, aged 61 and 59 years old, who are basically in good health.

She had an appendectomy at age 28, and a cholecystectomy at age 55, 1 month after her mother died. She sees her family doctor for control of asthma and high blood pressure. The same family doctor has treated the patient for nearly 20 years.

PRESENTATION OF THE PROBLEM

For much of the time he has known her, the family doctor has been aware of the patient's drinking problem. It apparently began in the early 1970s after she was involved in a lawsuit initiated by a parent of one of her pupils. Although the school backed her, and the case was eventually resolved in her favor, she remembers the 2-year period as one of constant fear and uncertainty. She recalls subsequently experiencing blackout spells. On 3 separate occasions, she was hospitalized for detoxification, and brief periods of sobriety ensued. The doctor inquires regularly about her alcohol habit and believes that the patient is mostly truthful about her bouts of drinking and times of abstinence.

One week ago, her husband and a daughter called to request time to "talk about mother." The husband related that his wife had resumed daily drinking (about 1 pint of vodka) 3 months ago. At times, he noticed that she slurred her words. Daughter has become fearful of leaving the grandchildren with the patient. When they each spoke with her, she denied "heavy drinking" and thought they made "more of the problem than there was."

The doctor agreed to talk with his patient, telling her that her husband and daughter had spoken with him, and she agreed to come in for an appointment. He pointed out, skillfully, that the problem was not new, that it was having marital and family consequences for her, that she had made several unsuccessful attempts to deal with it in the past, and that he felt it was time to take a definitive step to resolve the problem. He was somewhat surprised when she agreed to accept a referral to a psychiatrist for brief psychotherapy.

PSYCHOTHERAPY

The patient came to my office in late September 1997. She validated the history of her alcohol habit, as presented to me by her primary care physician. She added her several brief attempts to attend Alcoholics Anonymous (AA) meetings, until 1 year earlier when she quit because she "was bored." She described her mate as a "workaholic who is domineering and often makes me feel defensive." She acknowledged drinking daily for the past 3 months. She had slept poorly for 6 months, which she attributed to "bronchitis and a chronic cough." Her energy, appetite, and weight were all stable. She denied depressed or anxious mood.

She was kempt, cooperative, and appropriately behaved. Her mood was stable, and her affect was full in range. There were no psychotic symptoms, no suicidal ideas, and no obsessions or compulsions. She qualified for no psychiatric diagnoses save alcohol abuse. We contracted to meet every 2 weeks for up to 10 sessions to attempt to help her solve her alcohol problem.

In session 1, identifying parameters and a narrative history were achieved. In session 2, I taught her the cognitive model for understanding behavior and suggested that this was the framework we would employ. When there was a distressing feeling or an alcohol-related behavior, we would seek to identify the relevant meanings she applied to a situation. I stressed the relationship of cognitions (thoughts), feelings, and behavior. For homework, I asked her to keep a Triple Column, listing situations, feelings, and thoughts relevant to the urge to drink. In session 3, we sought to identify alternative choices to drinking and examined their consequences. During a 1-week vacation, her

drinking habit sharply declined. We discussed various meanings for this. By session 4, she reported 10 days that were alcohol-free. She identified cognitions preceding earlier drinking as "to have nerve" and "to forget an insult." Many of the meanings she offered were polarized, and we discussed this error of "black and white thinking." Together, we sought alternatives that were "grays." I suggested that she had successfully taken the first step toward change. In session 5, she reported nearly a month of continuing abstinence. She believed that a key to her success lay in applying the model when she anticipated a "drinking situation" and working with the identified meanings. She noted her difficulty with assertion and how a conversation with her husband seemed like "an interrogation" by him.

In session 6, she focused on a visit by her grandchildren, with its attendant demands and problems. She had remained abstinent for 6 weeks and noted how her mood was "more even" and that she angered "less easily." We defined this phase as "successfully having stopped drinking," but noted as well that she had achieved this before. The harder task would be maintenance. We searched together for potentially high-risk situations we could anticipate and plan for.

In session 7, she talked about 2 slip-ups. We worked to understand each situation in cognitive terms and examined alternate meanings, their consequences, and behavioral options. In session 8, she reported believing that she had achieved control over the alcohol habit, and that she felt "free" for the first time in years. We arranged a follow-up visit for 1 month later.

In our final meeting, we separated drinking alcohol as a habit from choosing to drink, in light of the consequences to her of an alcohol addiction. We utilized "shift of set," in which she was encouraged to advise a person in a story who had a range of alcohol-related problems. We discussed the positive value of our relationship, the work we each had done, and what she had found useful in the cognitive method. I encouraged her to call if another meeting would be helpful.

We terminated psychotherapy after 9 sessions conducted over a 5-month period of time. I sent a letter summarizing the treatment to her primary care physician. Six-month follow-up indicated continued abstinence. Individual psychotherapy was appropriate in this instance since AA had been initiated and proved of little help to the patient. Group therapy would be a reasonable alternative, depending on the group's focus.

Editor's note: Dr. Schuyler is a board-certified psychiatrist at the Medical University of South Carolina in Charleston who works halftime in a medical clinic. As a follow-up to his article "Prescribing Brief Psychotherapy" (February issue), Dr. Schuyler and colleagues will discuss cases referred by primary care physicians. Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

For further reading: *A Practical Guide to Cognitive Therapy.* 1st ed. by Dean Schuyler, New York, NY: WW Norton & Co; 1991. ISBN: 0393701050