Alcohol use disorder

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Alcohol use disorders are among the most prevalent mental disorders worldwide and rank high as a cause of disability burden in most regions of the world. (Grant et al. , 2006)The following paper discusses the recent research findings and essential features based on the content of diagnosis, assessment and treatment. Diagnosis The DSM-IV-TR classifies drug disorders into substance use disorders (substance dependence and abuse) and substance-induced disorders (substance intoxication, substance withdrawal, induced delirium, anxiety, depression, psychosis and mood disorders).

Sometimes it is difficult assessing patient’s psychiatric complaints because heavy drinking is associated with alcoholism can co-exist with, contribute to or result from several different psychiatric syndromes. (Shivani, Goldsmith & Anthenelli, 2002) In order to improvediagnosticaccuracy, distinguishes among alcohol-related psychiatric symptoms and signs, alcohol-induced psychiatric syndromes and independent psychiatric disorders that are commonly associated with alcoholism emerges to be essential. Patients’ gender, familyhistory, and course of illness over time also should be taken into account.

Alcohol-related psychiatric symptoms and signs Heavy alcohol consumption directly affects brain function and brain chemical and hormonal systems known to be involved in many common mental disorders thus can manifest itself in a broad range of psychiatric symptoms and signs. (Koob, 2000) And this usually the first problem which brings the patients seek help. The symptoms vary depending on the amount of alcohol used, how long it is

used and how recently it was used as well as patient’s vulnerability to experiencing psychiatric symptoms in the setting of consumption.

For example, during intoxication, smaller amount alcohol may produce euphoria whereas larger amount may produce more dramatic changes in mood. Alcohol also impairs judgment and aggressive, antisocial behaviours that may mimic certain externalizing disorders such as ASPD. Alcohol-induced psychiatric syndromes The essential feature of alcohol-induced psychiatric syndromes is the presence of prominent and persistent symptoms, which are judged- based on their onset and course as well as on the patient’s history, physical exam, and laboratory findings to be the result of the direct physiological effects of alcohol.

Given the broad range of effects of heavy drinking may have on psychological functioning, these alcohol-induced disorders p several categories of mental disorders, including mood, anxiety, psychotic, sleep, sexual, delirious, amnestic anddementiadisorders. Alcoholism with comorbid, independent psychiatric disorders Alcoholism is also associated with several psychiatric disorders that develop independently of the alcoholism and may precede alcohol use and abuse.

One of the most common of these comorbid conditions is ASPD, and axis IIpersonalitydisorder marked by a longstanding pattern of irresponsibility and violating the rights of others with alcohol. (Stinson et al. , 2006) Assessment The three major purposes for a comprehensive assessment are to determine a diagnosis, devise a treatment plan and to make appropriate referrals. The assessment should provide a clinical picture of the client’s personal level of

functioning, history, presenting problems, family and social context in the client’s life.

It is very important that the assessment process requires the gathering of comprehensive, accurate information, for a valid diagnosis and appropriate treatment. - It is vital that the counsellor needs to collect valid and reliable information. Both formal diagnosis, as listed in the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) and informal diagnosis, if the client has had therapy in the past can be made. - Comprehensive assessment is essential in designing a treatment plan.

The more information provided concerning the etiology, functioning level and prognosis of the problem, the better the treatment plan. - Comprehensive assessment also provides information in order to made appropriate referral. The counsellor may decide to provide treatment solely or in conjunction with some other drug treatment specialists. Generally there are three categories of assessment measures: subjective data and physiological data. -Subjective data To collect information of demographics, family and living situations, mployment, education, drinking history (including development of the drinking problem and current drinking) and the effects on the subject’s cognitive, psychosocial, behavioural and physiological functioning. (Aalto & Seppa, 2005)

For example, some questionnaires focus on problems caused by alcohol consumption, the Alcohol Use Disorder Identification Test (AUDIT) (Saunders, Aasland, Babor, de le Fuente, & Grant, 1993) There are ones with diaries focussing on the quantification of alcohol consumption, such as quantity-

frequency, time-period or time-line follow-back methods. Webb et al. , 1990) More recently, a low level of response (LR) to alcohol (the need for higher amounts to have an effect) is a genetically influenced characteristic that is both found in populations at high risk for future alcoholism and that predicts alcohol related life problems in future.

This Self-Rating of the Effects of Alcohol (SRE) questionnaire asks for estimate of number of drinks required to produce each of four effects at different times in their lives. Miller, Thomas, & Mallin, 2006) In addition, the survey included the Alcohol Use Disorders Identification Test-C (AUDIT-C), a three-question alcohol screening test adapted from the original AUDIT developed by the WorldHealthOrganization for use in primary health care. The AUDIT-C is a simple, reliable screening tool that focuses on the frequency of drinking, quantify consumed on the typical occasion and the frequency of heavy episode drinking. (Bush, Kivlahan, McDonnell, & al. , 1998)

Again, there is no such perfect measure that SRE was found to be biased and not able to identify high functioning middle-age women. Schuckit, Smith, Danko, & Isacescu, 2003) The difficulty with these specific questionnaires is that people who drink alcohol in general tend to neglect or underestimate their alcohol consumption. (Koch et al. , 2004) The accuracy of these measures is based on the patient's awareness of and willingness to acknowledge his or her pattern and level of alcohol use as well as negative effects of drinking. At least some individuals who drink excessively will fail to do this. (Allen & Litten, 2001) - Physiological data

Comparing to subjective data, physiological data can overcome the subjectivity, underestimation in particular thus provides more precise and objective information about the drinking issue. It includes general medical and psychiatric history and examination. This is conducted through screening of blood, breath or urine for alcohol used, further on laboratory tests for abnormalities that may be accompanied acute or chronic alcohol use such as gamma-glutamy-transferase (GGT) or mean corpuscular volume (MCV), a measure of the average size of red blood cells.

These may also be used during treatment for potential relapse. GGT is the most commonly used biochemical measure of drinking. However, it is not clear how much drinking is actually needed to cause GGT levels to elevate. And MCV tends to miss more alcoholics than GGT as MCV may be elevated by a variety of conditions other than heavy drinking such as non-alcoholic liver disease, smoking, advanced age or use of anticonvulsants etc. Thus applying the usual cut-off points for these tests, GGT turns out to have a low specificity whereas MCV shows a low sensitivity.

This may lead to a gross misunderstanding with the patient and unnecessary further testing. Carbohydrate deficient transferring (CDT) has been recently approved as a marker for identification of individuals with alcohol problems as well as an aid in recognizing if alcoholic patients in treatment have relapsed. CDT and GGT appear to validly detect somewhat different groups of people with alcohol problems. GGT may best pick up those with liver damage due to drinking, whereas CDT seems to be related to level of consumption with or without liver damage.

It should be kept in mind that biomarkers do not identify women or adolescents with alcohol problems as they do for male or adults in general. (Similarly, self-report screening tests are also generally less able to detect alcohol problems) (Allen & Litten, 2001) Previous studies showed that over 80% of internists and family clinicians report that they usually or always ask new outpatients whether they drink alcohol. Less than 20% of primary care physicians routinely use validated self-report alcohol screening instruments (e. g. CAGE questions or AUDIT) Fewer than half ask about maximum alcohol consumption on one occasion.

Alcohol biomarker laboratory tests are rarely used. Reasons given by clinicians for not following recommended alcohol screening guidelines range from lack of time, to insufficient knowledge and skills, to pessimistic attitudes about the ultimate benefits of screening. A current study conducted by Miller, et al. , (2004), they found that approximately 60% of clinicians surveyed frequently screen patients for alcohol use with quantity/frequency and CAGE questions.

This is comparable to the incidence of screening found in previous studies. (Miller, Ornstein, Nietert, & Anton, 2004)Miller, et al. 2006) further found that over 90% of patients were in favour of screening and guidance about alcohol use and very positive about the use of biological alcohol markers. These findings suggest that physicians and clinicians may be convinced that patients are open to alcohol screening and would not be offended by it. Heavy drinkers may have more of a tendency to be embarrassed by such questions but there is no evidence they would be object to screening. The

majority of patients would also be willing to receive alcohol biomarker blood tests, if their physicians and clinicians deemed such tests necessary.