Editorial article

New perspectives for the treatment of alcoholism

Nuevas perspectivas para el tratamiento del alcoholismo

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Throughout the years, the term alcoholism has undergone conceptual changes related to the progress of medical knowledge and social, political and economic changes. The new treatment perspectives are born from these changes and the need to have new therapeutic approaches that offer a broad and realistic answer to the varied problems caused by alcohol. Alcohol use disorder (AUD), previously known as alcohol dependence syndrome or alcoholism, is the most relevant one.

Alcohol consumption has a high impact on the health of the individuals. In Europe, it is responsible for 11.8% of premature mortality and also bears an important cost for the society, accounting for around 1.58% of the gross domestic product (GDP). Despite the existing pharmacological and psychosocial treatments and preventive policies, the efforts to minimize its impact on health and to reduce the associated economic cost are still insufficient, largely because alcoholic beverages are very accessible, inexpensive and excessively promoted (in Spain, more than a million Euros are spent daily in the promotion of alcoholic beverages). In Spain, during the last 12 months, 78.7% of the population aged between 15 and 64 years old has drunk alcoholic beverages, and 23.1% admitted that they had got drunk. More than 5.6% of the patients treated in primary care have AUD, and out of them, only one every 10 patients receives treatment. Besides, a general rule, such treatment is initiated more than 10 years after the beginning of the disorder.

An important reason that explains the scarce demand for treatment is the stigma associated to alcoholism, which generates dichotomous approaches (to be or not to be alcoholic) that compli- cate the acceptance of the disease and are far from clinical reality, where AUDs appear as an entity with no solution in regards to their continuity and with progressive levels of seriousness. The good news are that the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), has taken a firm step in this direction. Besides, we the specialists also bear some responsibility as our therapeutic offer is very restricted (focused on abstinence) and we do not always consider the characteristics of the patient nor his own perspective of the disease. To increase the number of treatment requests, it is necessary to address alcohol consumption as a continuous process in which stigmas and labels are avoided, and which allows for providing varied answers based on the level of seriousness. For this reason, the term heavy use over time has been proposed as an alternative to substance use disorder. This new definition is centred on consumption quantification, to focus on an objective parameter (grams of alcohol consumed), as it happens with blood pressure or glycemia figures. The amounts consumed do not only correlate to diagnosis criteria and organic damage, but by focusing on a figure, they can facilitate the disease destigmatization.

Alcoholism classic conceptions postulated that the patient had to hit bottom, acknowledge his absolute failure and from there blindly accept the prescribed treatment. If any patient resisted, he had to be vigorously confronted: break them down to build them up. This philosophy has endured despite the absence of scientific evidence and in spite of going against the most basic principles of medicine. Fortunately, the XXI century is witnessing the consolidation of new physician-patient relationship models. In this regard, there is a broad consensus about the need to implement, also in relation to addictions, the person-centred care and shared decision-making models. These approaches provide the individual with a greater responsibility and make him part of the clinical decision-making process. This treatment model is specially beneficial to treat chronic diseases for which there are varied therapeutic alternatives and where the patient’s commitment to actively introduce changes in his behaviour and lifestyle is essential to improve both prognosis and life quality. It is about understanding how the disease affects the individual in a holistic manner, considering not only the biological deficiencies but also the psychological and social aspects. It has been demonstrated that the person-centred treatment increases the individual satisfaction and treatment adherence, and improves the disease prognosis. This new therapeutic management makes real sense in the treatment of AUDs because we have different therapeutic alternatives (abstinence, consumption reduction) and varied pharmacological and psychosocial treatments that have demonstrated to be efficient. Thus, the patient shall have an active role in the decision-making process relative to the treatment to be followed. In this way, not
only are we more respectful towards the patient, but we also increase his involvement in the therapeutic process and his adherence to it and, in turn, improve his prognosis.15

Shared decision-making necessarily implies the patient inclusion, and frequently the inclusion of his close relatives, in a crucial aspect of the treatment which is the definition of the initial therapeutic objectives. A therapeutic programme will be designed focused on abstinence or consumption reduction, based on the clinical characteristics of the patient as well as on his preferences and motivation level. The consideration of both alternatives (abstinence and reduction) as opposed objectives is a mistake, as they are complementary options that can be alternated in time in the same patient. Although abstinence is the safest option, consumption reduction is a valid alternative and it is not uncommon that it constitutes an intermediate step in the therapeutic process.13

Even if it seems obvious, it is important to note that psychosocial management is the basis of AUDs treatment. Evidence is sound enough to demonstrate the iatrogenic action of the ancient confrontational techniques, which unfortunately are still in use, and to confirm the efficacy of the brief intervention techniques,14,15 cognitive behavioural therapies,16 couple therapies17,18 and motivational treatments,18 among others. These last ones have become widespread not only due to their effectiveness but also because they fit in perfectly in the person-centred care model, and by basing their mechanism of action in the activation of the individual’s internal resources, better results are obtained with a smaller use of resources.10 The application of the new technologies, specially m-health or mobile-health, will probably allow a greater optimization of resources at short-term. In fact, interesting applications for mobile phones have already been developed that empower the patient in the management of his disease.19

Pharmacological treatments also play an important role in the management of AUDs: however, the effect of all of them is moderate,19 and they must be always used in the context of psychosocial management. Until very recently, all drugs were targeted at the maintenance of abstinence through diverse mechanisms: dissausive as disulfiram, craving (compulsive desire to drink) reducers, such as acamprosate, or priming (unrestrained impulse to continue drinking after the initial consumption) reducers, such as naltrexone. Nevertheless, drugs such as topiramate,20 gabapentin21 and naltrexone itself22 have shown efficacy in the reduction of consumption, and recently the European Medicines Agency has approved nalmefene as the first drug to be introduced in the market with the specific indication for the reduction of alcohol consumption.23,24

On the other hand, in the next months we will have the results of broad clinical trials with baclofen25 and sodium oxybate,26 which shall bring to the table the alternative of substitute treatments, little appreciated to date by clinicians and with scarce scientific evidence in that regard.2

In summary, nowadays the clinicians face the most complicated scenario ever, where the therapeutic alternatives have significantly broadened, and the patient can and should actively participate in the design and follow-up of his therapeutic programme. The “coffee for all” era is gone, and undoubtedly, with the new intervention models, the clinicians can take a decisive step towards the designatization of the disorder that causes huge social, health care and economic costs in the Western world.

References