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A Study of Factors Contributing To Relapse in Alcohol Dependence and Intra Group Comparison of Factors Influencing Delay In Treatment Seeking After Relapse

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Abstract: ***Background****: Alcoholism is a major mental and public health problem in developing countries like India. Social factors play vital role in unfolding of alcohol use disorders in any given population. Several factors beyond the confines of treatment settings influence the treatment outcome in alcohol outcome in alcohol dependence.* ***Aims****: 1. To study various psychosocial factors contributing relapse in alcohol dependence subjects. 2. To compare those factors in contributing early relapse. 3. To study various factors influencing delay in treatment seeking among relapsed patients. 4.To compare those factors among early and late treatment seekers.* ***Materials and methods:*** *100 alcohol dependent subjects were taken with relapse in drinking after de-addiction treatment during a period of 4 months from March 2017 to June 2017. Semi structured proforma, severity of addiction assessed by severity of alcohol dependence questionnaire(SADQ), alcohol relapse risk scale(ARRS), DUSOCS (Duke's Social support and stress scale) were employed and studied.* ***Results:*** *43% of the study population were between 31 to 45 yrs of age. 67 % were married. 68 % people relapsed into use of alcohol in less than 1 year. Only 8 % were maintained abstinence for more than 2 years. Reasons for relapse were family problems in 57%, peer pressure in 39% and alcohol craving in 19%.* ***Conclusion:*** *Hence in this study, it is concluded that family problems constituted 51 % for reason for relapse, followed by peer pressure and alcohol craving. Also it is found that nearly 50 % delayed their treatment for more than 6 months after relapse.*

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I. Introduction

Alcoholism is one of the major health related problems in India. It is characterized by much significant psychological, physiological and social dysfunctions which were associated with excessive and persistent use of alcohol. It is not only chronic but progressive disease characterized by the loss of control on their use of alcohol associated with psychological, physical, social and legal consequences. Consumption of alcohol has been rising greatly over the past 4 decades and also accompanied by rise in the physical, social and psychological problems related to the use of alcohol.

Due to the increase in production, promotion, distribution and availability of the alcohol along with the rapidly changing values in society has resulted in the increase of problems due to alcohol use and it emerged as an important public health problem in our country. On the other side, absence of proper rational policies and also the belief in government that the revenue from alcohol is useful for the society development were all aggravated the problems further more. In the reality, revenues from alcohol yielded only immediate gains but the losses and the impact of the rise in alcohol consumption persist to impair the society on a long term basis[1].

NIMHANS in the year 2006 did a study in Bangalore sponsored by WHO – SEARO (World Health Organization – South East Asia Regional Office). They found that 33% of adult males consume alcohol regularly. They also brought into the light the drinking pattern in women. They said 2% of women consume alcohol regularly. Urban based women have greater problems due to alcohol use[2].

In India 62.5 million people consumed alcohol as per an estimate by WHO in 2005. In that 17.4% were dependent to alcohol use3. And also 20 – 30 % people admitted in hospital were due to problems related to alcohol[4].

With the background of this much magnitude of problem in our country, people who seek treatment for alcohol use problems are also limited. Among them most of the people relapse into the drinking pattern frequently. There are several factors identified related to the relapse of alcohol drinking. That will be discussed in detail in the next section. Alcoholism is a chronic as well as a relapsing disorder. Alcohol dependence was

characterized by the prolonged cause of problems related to alcohol and persistent relapse vulnerability. Even with improvement of multiple domains in life with treatment, the relapse risk continues to be high after treatment. One important feature noted in patients before relapse is the urge to drink alcohol i.e. craving[5].

This chronic disease has many harmful consequences. There are some conditions like alcoholic cirrhosis of liver, alcoholic gastritis that are wholly attributable due to alcohol use. And also there are many diseases in which use of alcohol as a contributory factor like many forms of cancer, epilepsy, cardio vascular disease, importantly almost any forms of accidents / injuries[6]. The WHO reported recently that the use of alcohol was an important attributable risk factor for not less than 60 varieties of major disorders[7].

Even after that, treatment seeking after relapse is again a problematic area. One study states than relapse following treatment reaches 75% in first 3 – 6 months period[8].

So, in our study we tried to find various demographic factors associated with the risk of relapse in alcohol use and also we tried to find various factors contributing to delay in their treatment seeking after relapse. At last, we tried to compare the various risk factors associated with the relapse between people who present early to treatment with the late treatment seekers.

II. Materials and methods

The study was conducted in the Karpagam Faculty of Medical Science and Research, Coimbatore , a tertiary care center for Tamil Nadu.

Study population:

Adults who qualified for Alcohol dependence syndrome and got de-addiction treatment but relapsed into their drinking behavior were taken into the study. Both in patients and out patients of Karpagam Faculty of Medical Science and Research were included.

Sample size:

A total of 100 subjects of alcohol dependence syndrome with relapse in drinking after de-addiction treatment were taken.

Sample size calculation:

Since it is a prevalence study the sample size is calculated according to the following formula.

Sample size= $\sigma_l^2 * p * q / d^2$

σ_l=1.96; d=5%

By reviewing previous literature, the prevalence of alcohol dependence was identified as 6-8%[84].Hence p is taken as 7%.

1.96*1.96*0.07*0.93/0.0025 = 100.

Period of study:

The study was conducted for a total of 4 months from March 2017 to June 2017.

Sample method:

Consecutive sampling.

Study design:

Cross sectional study

(One hundred) 100 alcohol dependent individuals who were relapsed into alcohol use after a de-addiction treatment were included in the study.

Inclusion criteria:

1. Age 18 years and older.
2. Individuals who qualified for alcohol dependence according to ICD IO criteria.
3. Individuals who relapsed into use of alcohol after alcohol de-addiction program.

Exclusion criteria:

1. Patent with presence of major psychiatric illness.
2. Patient with history of head injury, neurological disease or hearing problems.
3. Alcohol dependent subjects who maintained abstinence after de-addiction program.

Operational design:

After obtaining the written informed consent from the participants as required by the intuitional Ethics committee.

The following questionnaire and scales employed.

1. Semi structured proforma
2. Severity of addiction assessed by severity of alcohol dependence questionnaire(SADQ)
3. Alcohol relapse risk scale(ARRS)
4. DUSOCS (Duke's Social support and Stress scale)

Semi structured proforma:

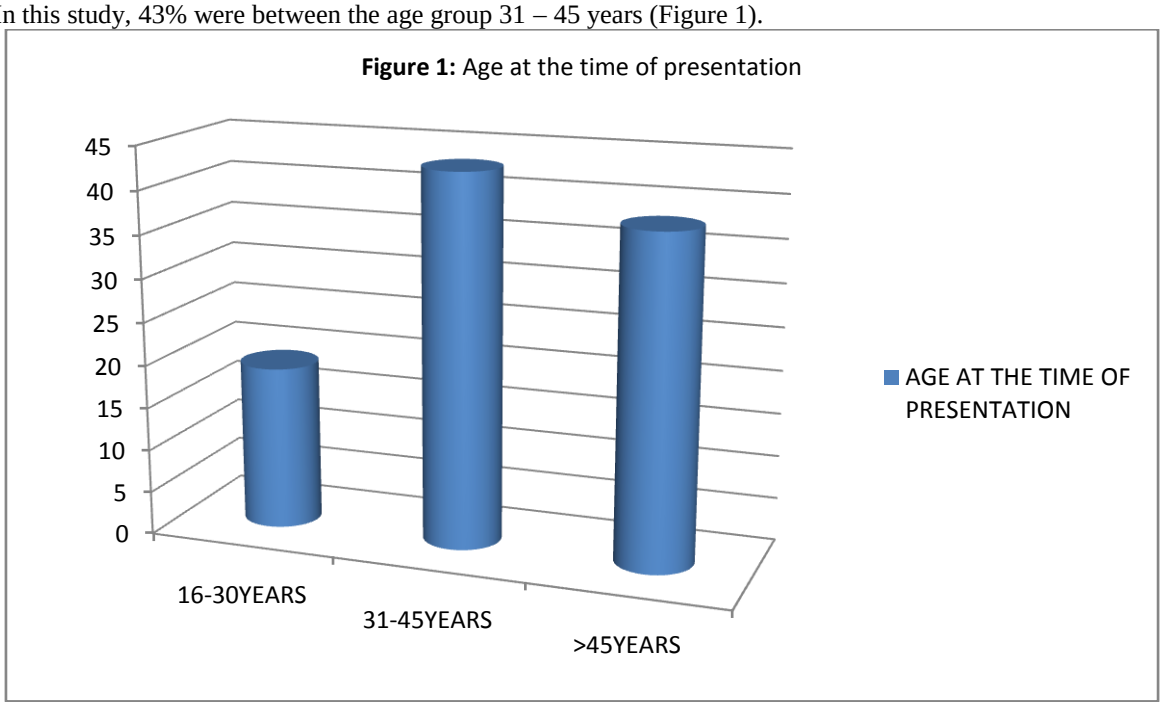
It is used to collect the patient's socio demographic profile which includes age, gender, occupations, income, and residence.

In the second part, details about their substance use were obtained. The age of onset of drinking alcohol, age of dependence, their treatment, the period of abstinence, relapse into the use of alcohol etc.
The reasons for relapse were also enquired in the same section.

III. Results

In this study, 43% were between the age group 31 – 45 years (Figure 1).

Figure 1: Age at the time of presentation



92% of alcohol dependents were males. 52% of alcohol dependents belong to semiskilled laborers (Table 1)

Table 1: Distribution of occupational status among alcohol dependent subjects.

	Frequency	Percent
Unskilled worker	19	19.0
Semiskilled	52	52.0
Skilled	29	29.0
Total	100	100.0

67% were married (Table 2).

Table 2: Distribution of marital status

Marital status	Frequency	Percent
Single	22	22.0
Married	67	67.0
Divorced	8	8.0
Widow	3	3.0
Total	100	100.0

65% belong to nuclear family. 68% of alcohol dependents had their first drink before the age of 20 years. 76% of alcohol dependents met the ICD 10 criteria for dependence before the age of 30 years.
SADQ > 30 denotes severe dependence.
55% in our study group belong to severe alcohol dependent people (Table 3).

Table 3: Severity of dependence by SADQ

SADQ SCORES	Frequency	Percent
0-15	3	3.0
16-30	42	42.0
Above 30	55	55.0
Total	100	100.0

Only 1% had depression in our study group. 68% people relapsed into use of alcohol in less than 1 year.
Only 8% maintained abstinence for more than 2 years.
57% people said family problems as their reason for relapse 39% as peer pressure, 19% said that they reused due to alcohol craving (Table 4).

Table 4: Reasons for relapse

Reasons for relapse	Frequency	Percent
Poor motivation	2	2
Craving	19	19
Peer pressure	39	39
Family problems	57	57

49% people presented for the treatment in 6 – 12 months delay. 84% presented for the treatment within a year. 16% presented only after 1year.
75% report social influence especially other social networks as reason for the delay. 56% report psychological influence especially not decided to stop drinking yet as a factor for their delay. 20% and 40% report situational influence and access barriers for the delay in treatment.

Table 5 compares the Duke's social support and stress scale between early and late treatment seekers

Table 5 : Comparison of duke's social support and stress scale between early and late treatment seekers.

Dukes social support and stress scale (DUSCOS)	DURATION_OF_DELAY	N	Mean	Std. Deviation	Std. Error Mean	t value	p value
Family_support	>1 Yr	16	30.3544	14.16462	3.54115	3.654**	p<0.001
	<1 yr	84	48.0696	18.35039	2.00219		
Non_Family_support	>1 Yr	16	23.7500	19.95829	4.98957	0.079	0.937
	<1 yr	84	24.1429	17.79071	1.94113		
Social_support	>1 Yr	16	30.1100	13.05443	3.26361	2.693**	0.003
	<1 yr	84	42.5146	17.48708	1.90800		
Family_stress	>1 Yr	16	52.6750	23.30858	5.82714	4.193**	p<0.001
	<1 yr	84	31.0767	17.96686	1.96034		
Non_Family_Stress	>1 Yr	16	43.1250	26.00481	6.50120	5.483**	p<0.001
	<1 yr	84	13.5714	18.40919	2.00861		
Social_Stress	>1 Yr	16	52.8381	12.29701	3.07425	7.893**	p<0.001
	<1 yr	84	26.7854	12.06508	1.31641		

There were statistically significant scores on family and social support which were high among early treatment seekers. i.e< 1 year.
Similarly there is statistically significant difference on stress scale, that all types of stress, family stress, non family stress and social stress were high among these who presented for the treatment above 1 year.
Total mean score in early treatment seeker – 12.2441
Total mean score in late treatment seekers – 12.775
The mean score of alcohol relapse risk is more or less the same between the group.
But in subscales, there is a statistically significant difference between two group in emotional problem,negative expectancy and positive expectancy. That is emotional problem were more in late treatment seekers. Similarly less negative expectancy and more positive expectancy were common among late treatment seekers.
There is statistically significant difference in age of presentation, occupation, education, marital status, age at dependence and severity of dependence between early and late treatment seekers. Those who seek treatment beyond 1 year of relapse belong to the age group 16 – 30 years. The higher the age, early the treatment seeking habit.
Similarly, these who seek treatment beyond 1 year were skilled laborers and educated more i.e higher secondary and graduates. Those who seek treatment early were married compared to those who delay their treatment.

Regarding alcohol use, individuals with earlier the age at dependence and more severe dependence delay the treatment when compared to others. There was no statistically significant difference in gender, residence, family type, age at first drink and duration of dependence between the two groups.

IV. Discussion

The study sample was 100 patients. The socio demographic profile and the pattern of alcohol consumption not only help us to understand the patient's background but also their influence on relapse. It is found that people who use alcohol has low educational level when compared to the control population. And also they found that major proportion were unskilled workers and married. These finding were replicated in our study also. We found that 62% were belong to the age group 16 – 45 years, nearly 71% were below 10th standard, 67% were married[1].

Korlakunta et al also confirmed more or less the similar findings i.e. majority were middle aged and married. 94.7% of their sample was also men. In our study also 92% were males. This showed that the problem due to alcohol relapse was common in males.

Korlakunta et al stated that 44% patients admitted that craving as their reason for relapse. Connors et al in 1998 did a study on the onset of relapse and termination relapse. They found that the factors contributing to relapse were desire to drink, psychological cravings, spouse or partner's factors and feeling down. And for termination of relapse they found that it was associated with a decision to stop. In our sample, we found that only 19% accept craving as reason for their relapse. They stated that family problems (57%) and peer pressure (39%) were the reasons for relapse.

In a study done by Nagaich et al stated that 97.9% of their samples were married the more responsibilities and less bonding with family cause them to restart their drinking habit. Our study confirmed this that 57% admitted that their family problems were being the reason for their relapse. In their study they found that 50.3% maintained abstinence for 2 – 6 months 38.9% for 7 – 12 months, 2.1% 13 – 18 months 1.1% 19 – 24 months and just 1.6% for 2 years 4 above most of them stated craving as their reason. In our study also we found 47% were maintained the abstinence upto 2 – 6 months, 68% till 1 year and 8% for more than 2 years[5].

A study by Kaundal et al also stated that the risk of relapse is high among people who have previous relapse and also the positive history of alcohol use in family. In the same study they found various parameters for relapse. Time to lapse 76.40 ± 17.35 days, time to relapse 138.40 ± 31.38 days, time taken to seek help after relapse 420 ± 119.31 days and SADQ score was 9.49 ± 3.89[9].

In regarding delay in treatment seeking 58% stated other social network delayed their treatment. Majority stated their own psychological influences particularly lack of control (56%) delayed their presentation to treatment. Only 28% stated that treatment related belief as barriers and another 12% stated the service proximity as their barrier to seek treatment. Saunders et al did a study on assessing treatment barrier conclude that important were person - related rather than treatment related delay factors[10].

Cunningham et al did a study on barriers to treatment in they concluded that the person related belief that their alcohol drinking is not a concern or not a problem is the important factor that delay their treatment.

Similarly in DUSOCS scales, social support were more among those who report early to treatment. This finding was again supported by various other studies. Vijayan et al did a study on alcohol dependents and their social support. They concluded that wellbeing in marriage help the alcohol dependent persons to recover from their addiction; they relapse less and cope better in their future. On the contrary, marital conflicts perceived as a deficit in support as well as stressor on chronic basis.

Another study by Dixit et al on social support concluded that many alcohol dependent subjects have dysfunctional relationship in workplace as well as family. They stated that abstinent group has better support than who relapse[11].

On comparing sociodemographic features between early and late treatment seekers, we found there was only significant difference noted in age and occupation.

V. Conclusion

Alcohol relapse is more common in the age group 31 – 45 years, more among males, majority were unskilled and semiskilled workers and belonging to lower educational status. And majority of the subjects who relapse were married and live in nuclear family.

Majority were started to consume alcohol below the age of 20 years, become dependent in the next 10 years i.e. 20 to 30 years. Those who relapse after treatment were severely dependent on alcohol.Nearly half of the subjects maintained abstinence after de-addiction treatment only for 6 months. About 2/3rd maintained abstinence for a year. Only 8% maintained abstinence for more than 2 years.

The following were the first 3 reasons for relapse elicited in our sample

1. Family problems (57%)
2. Peer pressure (39%)
3. Craving (19%)

While delaying treatment after relapse, only 27% reported within 3 months of relapse, nearly half of the people report by 3 – 6 months. Nearly 50% delay their treatment for more than 6 months after relapse.
Person related factors like doubting the need for treatment, public stigma were the important factors delaying the treatment rather than treatment related factors.
Those who seek treatment within 6 months of relapse have more social support and less stress.

References

[1]. Girish N, Kavita R, Gururaj G, Benegal V. Alcohol use and implications for public health: patterns of use in four communities. Indian J Community Med. 2010 Apr;35(2):238-44. doi: 10.4103/0970-0218.66875..

[2]. Minicuci N, Naidoo N, Chatterji S, Kowal P. Data Resource Profile:Cross-national and cross-study sociodemographic and health-related harmonized domains from SAGE plus ELSA, HRS and SHARE (SAGE+, Wave 1). Int J Epidemiol. 2016 Oct;45(5):1403-1403j.

[3]. Dhawan A, Rao R, Ambekar A, Pusp A, Ray R. Treatment of substance use disorders through the government health facilities: Developments in the "Drug De-addiction Programme" of Ministry of Health and Family Welfare, Government of India. Indian J Psychiatry. 2017 Jul-Sep;59(3):380-384. doi:10.4103.

[4]. Esser MB, Gururaj G, Rao GN, Jayarajan D, Sethu L, Murthy P, Jernigan DH, Benegal V; Collaborators Group on Epidemiological Study of Patterns and Consequences of Alcohol Misuse in India. Harms from alcohol consumption by strangers in five Indian states and policy implications. Drug Alcohol Rev. 2017 Sep;36(5):682-690. doi: 10.1111/dar.12470.

[5]. Nijhawan S, Katiyar P, Nagaich N, Saradava V, Nijhawan M, Gupta G, Mathur A, Sharma R, Nepalia S. Prevalence of associated disorders in Indian patients with celiac disease. Indian J Gastroenterol. 2013 Sep;32(5):330-4. doi:10.1007/s12664-013-0345-y.

[6]. Soyka M, Hasemann S, Scharfenberg CD, Löhnert B, Bottlender M. [New possibilities in treatment and rehabilitation of alcohol-dependent patients--acatamnestic study on the efficiency of outpatient treatment programmes demonstrated by a model procedure]. Nervenarzt. 2003 Mar;74(3):226-34.

[7]. Driessen M, Meier S, Hill A, Wetterling T, Lange W, Junghanns K. The course of anxiety, depression and drinking behaviours after completed detoxification in alcoholics with and without comorbid anxiety and depressive disorders. Alcohol. 2001 May-Jun;36(3):249-55.

[8]. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000 Oct 4;284(13):1689-95.

[9]. Hendershot CS, Witkiewitz K, George WH, Marlatt GA. Relapse prevention for addictive behaviors. Subst Abuse Treat Prev Policy. 2011 Jul 19;6:17. doi:10.1186/1747-597X-6-17.

[10]. Saha TD, Grant BF, Chou SP, Kerridge BT, Pickering RP, Ruan WJ. Concurrent use of alcohol with other drugs and DSM-5 alcohol use disorder comorbid with other drug use disorders: Sociodemographic characteristics, severity, and psychopathology. Drug Alcohol Depend. 2018 Jun 1;187:261-269. doi: 10.1016/j.

[11]. Dixit S, Chauhan VS, Azad S. Social Support and Treatment Outcome in Alcohol Dependence Syndrome in Armed Forces. J Clin Diagn Res. 2015 Nov;9(11):VC01-VC05. doi: 10.7860/JCDR/2015/14142.6739.

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