

A CROSS-SECTIONAL STUDY ON FACTORS INFLUENCING RELAPSE IN ALCOHOL USE DISORDER AND MOTIVATION TO STOP DRINKING ALCOHOL .

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Abstract.

Introduction:

Relapse into alcoholism following a successful detox and recovery program is a global public health concern. Despite the enormous burden of alcoholism on the Indian subcontinent, little is understood about the reasons why relapse occurs among people who have been treated for alcohol misuse.

Method:

In my study, 50 male patients who attended both the inpatient and outpatient departments (OPD) of a tertiary care hospital and had been diagnosed with alcohol dependency (per ICD-10 criteria) were included. Following informed consent and gathering sociodemographic information, the severity of alcohol dependence questionnaire (SADQ), the Presumptive Stressful Life Events Scales (PSLES), and the relapse precipitant inventory were used to correlate the factors that lead to relapse in these alcohol abusers.

Result:

A majority (100%) of the 50 patients included in the study were Male, with 50% coming from age 41-50 and a majority of 60% of the patients being educated from high school. Alcohol craving (60%) was discovered to be the most frequent reason for relapse in this group, and 90% of patients displayed moderate to severe stress on the PSLES scale.

Conclusion:

In India, excessive alcohol intake is becoming a significant public health issue. Along with occupational rehabilitation, consistent follow-up with family, peers, and social support is crucial to preventing recurrence. To better comprehend the issue, multi-centric scientific community-based research investigations must be carried out in several different states.

Recommendation:

Sensitization initiatives and health education efforts are desperately needed to raise awareness of the effects of chronic alcohol use among different policymakers, the media, professionals, and the general public.

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1. INTRODUCTION.

Many nations around the world struggle with alcoholism.[1] Alcohol-related disorders account for more than a fifth of hospital admissions in

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India, although primary care doctors don't always recognize them.[2] According to the National Family Health Survey, which was carried out by the Indian Ministry of Health and Welfare in 2014–2015, alcohol drinking was prevalent among men to the extent of 29%, with 12% of these users reporting a pattern of daily use. It was discovered that only 1% of women use alcohol, yet strangely, this group consumes alcohol at a rate that is higher than that of men (18%). [3]

A mental health condition known as alcohol use disorder (AUD) affects 3.6% of people worldwide between the ages of 15 and 64 [1]. The condition is quite common and has a significant impact on sickness and mortality globally [2,3]. Alcohol use disorder (AUD) is characterized by reduced control over consumption, which can result in physiological dependency and harmful psychological, social, and physical effects [3,4]. Numerous medical and mental health conditions, including major depressive disorder, generalized anxiety disorder, liver cancer, and hypertension are linked to the disease [2, 5-7].

Relapse is well documented to be correlated with several sociodemographic characteristics, including young age, male sex, unemployment, single status, peer group influence, family history of substance misuse, and inadequate family support. Two potential groupings of factors would appear to be crucial. The "internal state" of the patient, which may show as emotional states like anxiety and sadness, and the occurrence of events in the patient's life that upset his psychological homeostasis come first. The two factors interact. [10] Despite the various terminology used to categorize the determinant variables of relapse, it is crucial to remember that both personal and environmental factors can have an impact on the frequency and pattern of relapse.

The lack of a successful and effective long-term treatment strategy is a significant barrier to treating alcohol addiction. While the majority of de-addiction techniques help treat alcoholism in the short term, they fall short in the long run. The majority of patients who successfully detoxified experienced a relapse less than three months after beginning therapy.[5] Due to the high occur-

rence of relapse, some therapists have been forced to take a rather fatalistic stance and accept its impending inevitable. [6].

Due to the significant failure rates and hazards involved with restricted drinking methods, AUD therapies often require abstinence from alcohol [12,13]. A "relapsing condition," however, is what AUD is known as because individuals frequently relapse after quitting [14]. A lapse is defined as a single drinking incident within the AUD paradigm, whereas a relapse is a return to a pattern of problematic drinking [15]. According to Stillman et al.'s research [16], recurrence rates for those with AUD range from 60% to 80% after three months of therapy to 70% to 80% after one year. These figures underline how crucial it is for relapse prevention to be included in AUD treatment programs. These programs pinpoint individual characteristics that influence relapse and provide practical advice for better managing with cravings and mood swings. They also help identify triggers to lessen the frequency and severity of relapses [17-20]. The purpose of this study was to identify and examine the factors that influence relapse in alcohol usage disorder and also to motivate patients to stop alcohol drinking.

2. MATERIALS AND METHODS.

Fifty patients from the outpatient and inpatient units of the psychiatry department at Jawahar Lal Nehru Medical College and Hospital, Bhagalpur participated in a cross-sectional study conducted over two years. Patients between the ages of 18 and 65 who had been diagnosed by a consultant psychiatrist using the ICD-10 were chosen based on convenience sampling criteria and were present at the psychiatry OPD. According to the following inclusion and exclusion criteria, the subjects were chosen:

2.1. Inclusion Requirements.

- People who meet ICD-10 criteria for alcoholism, code F10
- Able to provide knowledge-based consent

2.2. Exclusion Standards.

- Patients with other significant psychiatric disorders
- Patients with behavioral or medical disorders that prevent them from answering the proforma
- Patients who are mentally retarded or have language difficulties data gathering. The information was gathered using a pre-made, semi-structured interviewer-administered questionnaire that included questions about personality, clinical profile, alcohol use profile, and socio-demographic profile. Urban and periurban communities' socioeconomic status (SES) was assessed using the Modified Kuppaswamy Scale [10] for Socio-Economic Class. Alcohol dependency was diagnosed using ICD 10 criteria. At the initial stage, 302 patients were examined for eligibility, however, 252 patients were excluded from this study due to not being eligible.

2.3. The Aware Questionnaire:

This survey included a 28-item scale (version 3.0)101 from Miller and Harris [13, 14]. This is a self-report questionnaire that the subject can complete. Make sure the subject is aware of the 1–7 grading scale. The earlier indicators of relapse that the client reports, the higher the score. The possible scores range from 28 (the lowest score) to 196 (the greatest score).

Semi-structured data collecting forms were used to collect the data. The results and observations were all coded and recorded into a single Excel file.

2.4. Statistical Analysis.

The means and standard deviations of the measurements for each group were employed (SPSS 22.00 for Windows; SPSS Inc, Chicago, USA). Data were statistically analyzed using factorial ANOVA for each assessment point. The level of significance was fixed at $p < 0.05$, and the student t-test and Fisher exact test were used to assess differences between the two groups.

3. RESULTS.

Every participant was a man. According to the age-wise distribution, as indicated in Table 1, the majority of participants were between the ages of 41–50 (50%) and 31–40 (32%) respectively. The majority of participant's education is in high school (60%).

Patients who had signed up for the study were asked why they had relapsed after receiving full detoxification and rehabilitation. The cases in the study sample exhibited numerous causes for relapse, with craving accounting for the bulk of them ($n=30$; 60%), followed by lack of motivation ($n=7$; 14%), and ($n=5$; 10%) having experienced one or more stressful events in the previous year (Table 2).

The level of stress the patients had experienced in the previous year—which may have contributed to relapse in alcohol-dependent people—was assessed using PSLES. The results (Table 3) demonstrated the mean presumptive stress score over the previous year, of which ($n=45$; 90%) had a moderate level of stress, while the remaining had a severe degree of stress. Of these, ($n=35$; 70%) had an ambiguous amount of stress, while the others accounted for desirable ($n=10$; 20%) and undesirable ($n=5$; 10%) amounts of stress.

4. DISCUSSION.

The goal of the current study was to evaluate 50 alcoholics (alcohol dependent) who were inpatients and outpatients at the psychiatry department of Jawahar Lal Nehru Medical College and Hospital, Bhagalpur for their motivation to stop drinking and their risk for relapse.

In the current study, all 50 participants were men. In a similar vein, only men participated in a study by Copeland [20]. In their study, 94.7% of men and 5.3% of women were found. According to the National Family Health Survey, which was carried out by the Indian Ministry of Health and Welfare in 2014–2015, alcohol consumption was prevalent among males at 29% and among women at 1%. Since the majority of the population in the catchment area of our hospital is rural, it is

Table 1: **Demographic and clinical distribution of subjects.**

Variables	N	%
Age	2	4%
>50	25	50%
41-50	16	32%
31-40	4	8%
21-30	3	6%
18-20		
Gender	0	0
Female	50	100%
Male		
Education	2	4%
Postgraduate	7	14%
Graduate	30	60%
High school	11	22%
Illiterate		

Table 2: **Reasons for relapse amongst patients with alcohol dependence.**

S. no.	Characteristic	No. of patients	Percentage
1.	Withdrawal	6	12%
2.	Craving	30	60%
3.	Stressful events	5	10%
4.	Peer pressure	2	4%
5.	Poor motivation	7	14%

Table 3: **Presumptive stressful events in the past one year as measured on the PSLES**

S. no.	PSLES stress category	N	%
A	Severe stress	5	10%
	Moderate stress	45	90%
Level of stress			
B	Undesirable	5	10%
	Desirable	10	20%
	Ambiguous	35	70%

likely that even if female alcohol consumption is common there due to the stigma attached, they are unlikely to seek formal treatment, so patients who present for de-addiction are primarily male [21, 22].

In a study by Trivedi et al. [18] on rural Uttar Pradesh residents, it was discovered that the majority of alcohol abusers who sought medical attention were over 30 years old (51.43%), with a mean age of 37.20 years. According to Korlakunta et al. [23] 2014, the bulk of the sample belonged to the middle age group, which is consistent with the current study's findings. In contrast, Sharma et al. [24] discovered that the majority (56.7%) of substance abusers were in the 18–30 age range.

The participants' average age in the current study was 39.27 ± 7.40 years. According to the age distribution, the majority of participants were between the ages of 41 and 50 (46.67%), followed by those between the ages of 31 and 40 (43.33%).

According to Pandey et al. [25], who observed nearly identical findings, the majority of patients in their study were between the ages of 31 and 50 (76%) and had a mean age of 42.64 years.

In my study, we used the URICA scale to measure the several stages of change experienced by my subjects, and we discovered that 33.33% were in the pre-contemplation stage, 36.67% were in the contemplation stage, 13.33% were in the action stage, and 16.67% were in the maintenance stage. According to Samokhvalov [9], at the time of presentation, 60% of the patients were in the pre-contemplative, 38% were in the contemplative, and 2% were in the action stage.

According to Witkiewitz et al. [11], the majority of participants were in the pre-contemplative (35%) and contemplative (32%) stages. Given the low number of participants in the action and maintenance stages, it is safe to assume that the majority of patients appearing for de-addiction do not share high levels of drive to change.

The mean pre-contemplation and contemplation scores were high in younger age groups, but action and maintenance scores were greater in older age groups, according to an analysis of age-wise correlation. Therefore, it may be claimed that age was not a factor in motivational stages.

Pandey et al. [25] reported similar findings in their investigation.

According to a multiple-factor analysis, the way a change is presented, the age at which it first occurs, the reason for starting, the duration of increased intake, the drinking pattern, the drinking style, and the reason for restarting do not appear to significantly affect the phases of change ($p > 0.05$). The presence of alcohol during working hours and frequent job changes had no impact on motivation. Although a family history of alcoholism has been shown to have an impact on several alcohol dependence-related factors, such as clinical profile, relapse, and the severity of alcohol-related problems, this study indicated that it had no significant impact on motivation ($p > 0.05$). These results were consistent with the research conducted by Pandey et al. [25]

According to a statistically significant correlation between the method of presentation—whether a patient was brought by others or came alone—and the amount of alcohol consumed by subjects at the time ($p\text{-value} = 0.02$), patients brought by others consumed significantly more alcohol than those who came alone.

Comparing participants who consistently consumed bigger amounts to those who consistently consumed smaller amounts, it can be inferred that the latter needed external incentives because the former lacked awareness and motivation to seek therapy.

The likelihood that patients brought by others had a much higher propensity for binge drinking patterns than those who came by themselves was demonstrated by the statistically significant association between manner of presentation—i.e., whether the patient came by himself or was brought by others—and pattern of alcohol consumption ($p\text{ value} = 0.01$).

This may once again reaffirm the earlier conclusion that patients who drink more alcohol in a shorter amount of time frequently lack awareness and drive to seek treatment and hence require external motivation in the form of family members or interventions from others.

Due to its cross-sectional design and small sample size, the current study has some drawbacks.

This study did not evaluate the relationship between treatment and outcome and motivation levels. Separate studies on these patients could be highly helpful in treating subjects who are addicted to alcohol.

5. CONCLUSION.

The majority of drug misuse treatment programs and self-help efforts are made to support patients who are motivated and deal with their issues. But those who aren't ready to change or who are just starting to change are also accepted into these programs. As a result, the majority of therapists must be able to deal with patients who are unmotivated or conflicted. With semi-structured measures like the Alcohol Use Disorder Identification Scale, the Advanced Warning of Relapse Questionnaire, and the University of Rhode Island Change Assessment Scale, only a small number of researchers have attempted to conduct a thorough assessment. Therefore, this study attempted to fill this gap.

6. LIMITATIONS.

The limitations of this study include a small sample population who were included in this study. The findings of this study cannot be generalized for a larger sample population. Furthermore, the lack of a comparison group also poses a limitation for this study's findings.

7. RECOMMENDATION.

Sensitization initiatives and health education efforts are desperately needed to raise awareness of the effects of chronic alcohol use among different policymakers, the media, professionals, and the general public.

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9. LIST OF ABBREVIATIONS.

OPD- Outpatient department
ICD- International Classification of Diseases
SADQ- Severity of alcohol dependence questionnaire
PSLES- Presumptive Stressful Life Events Scales
AUD- Alcohol Use Disorder
SES- Socioeconomic Status
SPSS- Statistical Package for Social Sciences
ANOVA- Analysis of Variance
URICA- University of Rhode Island Change Assessment Scale

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11. Conflict of interest.

The authors report no conflicts of interest in this work.

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