Epidemiological Profile and Subjective Reasons of Relapse in Inpatient Service Personnel of Alcohol Dependence Syndrome-A Cross-sectional Study

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ABSTRACT

Introduction: An elaborate understanding of reasons of relapse is essential for successful de-addiction treatment in an endeavour to guide patient towards recovery. In service environment implications of relapse are deleterious to service prospect of armed force personnel.

Aim: To explore epidemiological profile and subjective reasons for relapse in service personnels with Alcohol Dependence Syndrome (ADS) after de-addiction treatment.

Materials and Methods: The sample consisted of 100 consecutive male patients of diagnosed Alcohol Dependence Syndrome (as per ICD-10: WHO 1992) undergoing inpatient treatment for 1st relapse. Semi structured interview to enumerate individual's demographic profile, support system and other alcoholic milestones were taken into consideration. Reasons For Drinking Again Questionnaire (RFDAQ) was used to identify reason of relapse among relapse precipitants. The data was statistically analysed. Independence of the attributes was compared by use of Chi-square contingency table analysis.

Comparisons of the means in the groups was done using the student's t-test. A significance level of p<0.05 was accepted for all analysis. Non parametric t-test was also used.

Results: In our study the mean age of the participants was 38.03 years (7.92). Mean age of onset of alcohol use was 24.31 years (3.642). 64% of study group manifested with relapse within 03 months of de-addiction treatment and only 20 % could maintain sobriety for more than a year. In our study 65% relapse participants manifested with uncomplicated alcohol withdrawal followed by 25% with alcohol withdrawal delirium tremens and 5% with seizures. The most common reasons for resuming alcohol intake were feeling sad, drinking as a result of good mood and someone offering them a drink.

Conclusion: The reasons for resuming alcohol intake after achieving a period of abstinence were mostly intrapersonal factors like feeling of sadness and good mood followed by interpersonal issues like someone offering them a drink. Therapeutic implications are discussed.

INTRODUCTION

Alcohol dependence is a multifaceted psychiatric illness. It is one of the leading causes of death and disability globally. Alcohol is attributed to nearly 3.2% of all deaths and results in a loss of 4% of total DALY'S (58 million) [1]. In India, the estimated numbers of alcohol users in 2005 was 62.5 million, with 17.4% of them (10.6 million) being dependent users [2]. Most of the persons with early stage drinking problems visit primary care physicians with complaints of physical illness. Another core feature of this illness is the relapsing course, despite adequate pharmacotherapy and psychotherapy.

Relapse of substance abuse is defined as resumption of uncontrolled substance use. Relapse is more severe return to previous behaviour where as "lapse" is just initial "slip" or setback without failure to control [3]. Relapse is a complex process and it is best understood as having multiple and interactive risk factors that vary in their temporal proximity from their relative influence on relapse. Several authors have proposed relapse precipitant categorizations that incorporate the timing of the risk factors in relation to the drinking behaviour [4,5]. These can be categorized depending upon temporal proximity to relapse into proximal and distal risk factors. Proximal risk factors determine timing of relapse and distal risk factors determine who will relapse [4]. Proximal risk factors may include threats to self efficacy, craving, social cue reactivity, positive or negative affective state, stressful life events, loss of near or dear ones or acute psychological distress. Distal

risk factors include factors which increase vulnerability of relapse in individuals like genetic loading of alcohol, chronic alcoholism, dual diagnosis or accompanying physical illness, impaired cognitive abilities or increased reactivity to alcohol related cues [5]. Extra-treatment variables like social support have been found to be a strong protective factor that fosters resilience, either through resisting or helping to manage stressful events [6]. Thus understanding the nature of relapse is fundamental to developing effective interventions for long term treatment of alcoholism [7].

Marlatt Model is a detailed classification of factors or situations that can precipitate or contribute to episodes of relapse [3]. These include intrapersonal factors (within the individual) and/or reactions to non-personal environmental events. It incorporates cognitive behavioural model. These include Emotional States: (moods and feelings) of both positive and negative valence for example feelings such as frustration, anger, anxiety, depression and boredom. Life-skills deficits; are also commonly associated with relapse [8]. These deficits commonly include the inability to manage anger and inappropriate reactions to stress. Stowig's work supported the Marlatt model of relapse [9]. He highlighted that 72% of relapses occur as a result of intrapersonal factors. The study further reported that among participants, intrapersonal determinants accounted for an average of 52% of all cases of relapse, whereas interpersonal determinants accounted for 48%. Another study [10] found that the most frequent precursors to relapses were "painful emotional states

(40% of relapses), failure to enter aftercare following treatment (37%) and encounters with conditioned environment stimuli (34%).

The present study attempted to address this complex and intriguing issue pertaining to relapse in army community. Members of Armed Forces are not immune to Alcohol used disorders as it is one of the most common behavioural disorders in army. It is the cause of 15-20% of all psychiatric admission and many surgical and traumatic emergencies [11]. ADS affects combat readiness. In cases where satisfactory recovery and abstinence does not occur after repeated relapses during follow up then patients are invalided out of service [12].

Although there are many studies focused on the patterns of use, changing trends and health consequences but there are only few studies addressing the temporal factors related to relapse of substance use after successful de-addiction treatment in soldiers. Hence this study is an effort to identify and prioritize the modifiable factors that predict the vulnerability to relapse in cases of Alcohol Dependence Syndrome.

AIM

To explore epidemiological profile and subjective reasons for relapse in patients with ADS after de-addiction treatment.

MATERIALS AND METHODS

This was a cross sectional study to identify the factors related to first relapse in patients, following the treatment for Alcohol Dependence Syndrome (ADS). The study was conducted at the Department of Psychiatry at a tertiary care Army hospital in Delhi from January 2015 to December 2015. Ethical clearance was taken from the Hospital Ethics Review Committee. All consecutive patients who were earlier diagnosed with ADS (as per ICD -10: WHO 1992) and now admitted following first time relapse drinking of alcohol were included in the study.

Those patients with multiple relapses, multiple substance use or co-morbid medical or psychiatric illness were excluded. For the purpose of the study, remission was defined as complete abstinence from alcohol at least for a month and relapse as reinstatement of dependent pattern of drinking as per ICD-10 criteria. All patients were evaluated with: **a)** Semi structured interview questionnaire to enumerate demographic profile, support systems and other variables related to alcohol use like age of onset of drinking alcohol, duration of dependence, duration of inpatient de-addiction treatment, number of follow ups etc; **b)** CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol-revised) [13] scoring immediately after admission then every six hours, as a routine protocol of the ward; **c)** Reasons For Drinking Again Questionnaire (RFDAQ). It is a 20 item self-report measure that was designed to identify reasons of relapse among relapse precipitants within three broad domains: negative emotions, social pressure and craving [14]; **d)** Relevant neuroimaging and laboratory tests were performed. After the completion of detoxification treatment, written informed consent from each patient was obtained. Information from the spouse/family members if staying along with the patient and/or unit report was also collected for analysis.

The data was statistically analysed using Statistical Package for Social Sciences (SPSS) (version 22) computer software package. Appropriate parametric/non-parametric tests were used for continuous data. For categorical data, Chi-square test was used. A significance level of $p < 0.05$ was accepted for all analysis.

RESULTS

100 patients of ADS relapse (first relapse) were admitted during study duration. Mean age of the subjects was 38.02 (SD 7.79). The most vulnerable age group in the study was 36-49 years; comprising 50% of the relapsed subjects followed by 40% in the 26-35 years age. Mean age of onset of drinking was 24.31(SD

3.642) years. 39 % cases were drinking for 11-15 years followed by 32% drinking alcohol for the last 6-10 years. 20% were sober for more than one year duration while 28% could be sober only till 2-3 months. A 33% patient had followed up monthly in addiction clinic following initial treatment while 19% never followed in person after initial treatment and discharge. 27% had just one time follow-up after initial treatment. While 5% patients could maintain a week-end pattern of drinking while 57% were drinking daily. Majority (88%) of the subjects were married, 37 % of respondents were 12th qualified followed by 31% as 10th Standard qualified, 15% were educated only till 8th class and 11 % were degree holders [Table/Fig-1].

Support from significant others like superiors, colleagues, spouse and other family members was available in 79, 71, 73 and 85% patients respectively. The lack of support was perceived from religious groups, friends and after care services by 85, 79 and 74% of people respectively [Table/Fig-2].

The rank order of reasons for relapse was as following: 52% cited 'feeling sad' as reason (stated they felt sad and had to give in), 40 % reported that they felt like drinking due to good mood & an equal percentage agreed to that they drank again as someone offered them a drink [Table/Fig-3].

	Mean with SD	Frequency %
Age	38.02 (7.79)	-
Age Distribution		
18-25	2	(2%)
26-35	40	(40%)
36-49	50	(50%)
50-60	8	(8%)
Marital Status		
Divorced	4	(4%)
Single	6	(6%)
Married	88	(88%)
Separated	1	(1%)
Widower	1	(1%)
Education		
Upto 8	15	(15%)
9-10th class	31	(31%)
11-12th class	37	(37%)
Diploma	5	(5%)
Degree	11	(11%)
PG	1	(1%)
Total Duration of Drinking		
<5 years	13	(13%)
6-10 yrs	32	(32%)
11-15 yrs	39	(39%)
>15 yrs	16	(16%)
Quantity of Alcohol use		
60-120 mL	6	(6%)
120-180 mL	18	(18%)
180-240 mL	30	(30%)
240-300 mL	23	(23%)
300-360 mL	19	(19%)
360-420 mL	1	(1%)
>420 mL	3	(3%)
Frequency of Alcohol use		
1-2 times/wk	11	(11%)
3-4 times/wk	21	(21%)
Daily	57	(57%)
Weekdays only	6	(6%)
Weekends only	5	(5%)
Duration of Initial Inpatient Detoxification & De-addiction		
Upto 2 Wks	5	(5%)
2-4 wks	32	(32%)
>01 months	63	(63%)
Duration of Sobriety after deaddiction treatment		
Less than 1 month	26	(26%)
1-2 months	10	(10%)
2-3months	28	(28%)
3-6months	8	(8%)
6-12 months	8	(8%)
More than 12 months	20	(20%)

[Table/Fig-1]: Epidemiological Profile.

Received Support From	Yes		No	
	N	%	N	%
My Superiors	79	79	21	21
My colleagues	71	71	29	29
My spouse	73	73	27	27
My family (other than wife)	82	82	18	18
After care sessions at the rehabilitation centre	26	26	74	74
Support group sessions e.g Alcohol Anonymous	29	29	71	71
My Community (friends)	21	21	79	79
My religious group	15	15	85	85

[Table/Fig-2]: Frequency distribution of support received after de-addiction treatment and before presenting in a relapsed state.

Reasons for drinking again	Strongly Dis-agree		Disagree		Neither agree nor disagree		Agree		Strongly Agree	
	N	%	N	%	N	%	N	%	N	%
Q15.1 I felt angry with myself because things were not going my way.	63	63%	9	9%	5	5%	12	12%	11	11%
Q15.2 I felt frustrated with myself because things were not going my way.	57	57%	10	10%	8	8%	12	12%	13	13%
Q15.3 I felt bored.	52	52%	14	14%	20	20%	09	9%	05	5%
Q15.4 I felt anxious.	53	53%	23	23%	11	11%	07	7%	06	6%
Q15.5 When I saw alcohol I just had to give in.	46	46%	13	13%	18	18%	13	13%	10	10%
Q15.6 I felt sad.	26	26%	13	13%	09	9%	23	23%	29	29%
Q15.7 I felt physically ill.	79	79%	14	14%	02	2%	04	4%	01	1%
Q15.8 I felt pain.	79	79%	08	8%	04	4%	03	3%	06	6%
Q15.9 I was in a good mood and felt like getting high.	36	36%	08	8%	16	16%	17	17%	23	23%
Q15.10 I wanted to see what would happen if I tried one drink.	49	49%	11	11%	13	13%	11	11%	16	16%
Q15.12 Someone offered me a drink.	36	36%	08	8%	16	16%	17	17%	23	23%
Q15.13 I felt Frustrated because of my relationship with someone else.	81	81%	06	6%	03	3%	02	2%	08	8%
Q15.14 I was with others having a good time and we felt like getting drunk together	60	60%	05	5%	06	6%	20	20%	09	9%
Q15.15 I felt ill or in pain but this was not due to withdrawal from alcohol.	80	80%	09	9%	02	2%	04	4%	05	5%
Q15.16 I felt others were being critical of me.	65	65%	10	10%	17	17%	04	4%	04	4%
Q15.17 I saw others drinking.	47	47%	10	10%	12	12%	17	17%	14	14%
Q15.18 I discovered I have a terminal illness/ my health began to deteriorate due to my health status.	91	91%	05	5%	01	1%	02	2%	01	1%
Q15.19 I felt I could not cope with my stressful work environment	81	81%	05	5%	03	3%	06	6%	05	5%
Q15.20 I was transferred to another more stressful department at work	86	86%	06	6 %	03	3 %	02	2%	03	3%

[Table/Fig-3]: Reasons for drinking again Questionnaire.

DISCUSSION

Alcohol Use Disorder is a chronic relapsing illness which is incompatible with military ethos and training. Earlier the reasons of the relapse are studied in soldiers, the better they could be mentored at cognitive behaviour level. Each relapse shall be viewed as an important step in the path of abstinence and hence this study focused on the background of soldier and first relapse following first treatment so that early active intervention could be formulated to improve outcome in light of knowledge gained.

Preventing relapse is a huge challenge for de-addiction specialist. During first three months post treatment relapse rate was reported as 58% by researches [15]. This increased to 90% by 4 years with at least one relapse [16]. Host, agent and environment interact in complex ways to produce relapse [17]. The correlates of relapse and its role as a predictor of long-term prognosis has not received its due attention and importance.

Mean age of patients were 37-38 years in current study is similar to results found in other studies [18-20]. Similar findings were reported in Armed Forces too [21]. The most vulnerable age group in our study has been 36-49 years; comprising 50 % of subjects [Table/Fig-1]. Another study stated that 64% of relapse participants were in age group 31-45 years [19]. Thus the intervention strategies focused on this age group can lead to significant reduction in

alcohol related disorders as well as DALY's lost. Educational qualification in our study was higher than the figures obtained by other Indian researchers [22,23]. Army has increased the minimum requirement for enrollment gradually to 12th standard. Poor educational achievement was reported with the increased risk of alcohol disorders [22]. The study on burden and impact of alcohol showed the greater use of alcohol among those who had less than 8th grade of education [23].

The mean age of onset of alcohol use 24.31 years and mean age of relapsed subjects 38.03 years suggests a significant time of around 14 years elapsed when they progress from onset of drinking to fully dependent drinking to face first relapse. Military researchers reported lag period of about four years between onset of drinking and its regular consumption [24]. Earlier the intervention better is the prevention. Hence during the training period in Regimental centers adequate emphasis on hazards of alcohol should be taught to recruits before induction in operational areas. Zonal combat training schools should also deglamorize drinking and remove myth about expectancy of positive outcome observed to be leading to onset of drinking [25]. Western researchers have reported that individuals who began drinking at younger ages were more likely to experience relapses and requiring prolonged treatment. A 28% had reported drinking onset at age 13 years [26]. This is may be due to cultural permissiveness in western world as compared to India. During younger days, soldiers spend more time in hard and harsh terrains and in operational areas to meet national priorities. During this period, both first responders (administrators) and second responders (health care givers) need to be more vigilant in identifying drinking behaviours.

Often, a soldier in Indian Army, is sent for de-addiction, after he has been adequately counseled by his unit authorities and sufficiently warned/cautioned to reform himself. This could increase the lag period for medical attention. Hence referral for evaluation and management of substance use disorders should be done at the earliest rather than at later stage for healthy and productive outcome of treatment.

Maintaining sobriety, post treatment for ADS is a big challenge due to multiple factors. In our study there was increased rate of abstinence. After a year, around 20% were abstinent as compared to 2.1% reported around 13-18 months by others in civilian population [19]. This can be explained by the fact that, in military setting, once a mental illness is diagnosed; there are defined and well-structured protocols for regular follow up of cases post discharge e.g., monthly review, 06 monthly reviews at the dependent psychiatric center for mandatory two years. Hence there is better monitoring of relapse or drug default. Other factors which possibly contributes to better rate of alcohol abstinence After treatment in Indian army soldiers, are fear of loss of job and loss of promotion to higher ranks. However, at six month, abstinence rates were better in civilian population (56% vs 36%).

Support received after the de-addiction treatment is important factor to delay relapse. Social support in soldiers is primarily in reference to two categories: support from within the military (e.g., perceived unit cohesion and support from military leaders and fellow personnel) and support from outside of the military (e.g., social support from family and friends). Alcoholics post discharge & treatment face range of challenges and stressors. Direct advice from pro-abstaining leaders, partners and co-workers, informal sharing with other junior colleagues may help in remaining abstinent [27]. The lack of critical comments, hostility and empathy expression towards the treated individuals does augment the recovery process. It was not surprising that from superior colleagues, spouse and other family members support was perceived before relapse. However despite the army being a large community the network therapy is not well established. Alcohol Anonymous group are scanty and sparse across the Armed Forces. Professional counselors and social workers are rare precious commodities in service hospitals due to acute shortage. Thus additional source of support when individual is in post treatment setting in community is hardly available to tackle the negative emotions and solving conflicts between the ill and their families or the environment. Hence army needs to invest more resources and men. Army requires the presence of psychologists in various centers of detoxification. They could be an additional source of support, constructively assisting in recovering within the community. The other solution is organizing groups of self-help where people affected by similar problems try to combat adversities. They provide support understanding and share experiences in solving of common problems or show and receive acceptance which helps alcoholic to maintain their self-esteem.

When reasons for relapse were analysed our results were consistent with earlier research [17] where it was indicated that the predominant factor was negative emotions from both the intrapersonal and interpersonal domains, followed by social pressure and lastly wanting to get high, testing control, substance cues and urges to drink. In a study of 30 male patients of ADS when precipitating factors of relapse were noted authors reported reduced cognitive vigilance being first ranked antecedent for relapse followed by external situations and euphoric states as well as unpleasant mood states as reasons for relapse [28]. Another study reported craving as an antecedent factor preceding relapse in Armed Forces [29] but multiple relapse cases and different instrument to assess the reason for relapse were taken. They however reported negative motions like feeling sad, then being happy and consumption due peer pressure as next commonest antecedent factors for relapse.

In our study, we looked into first relapse in the Indian soldiers who were healthier people drawn from civilian population. After tough training they underwent health check up every year. This was reflected in the current finding that majority of the subjects did not report health reasons or change in the environment/stressful environment as a reason for relapse. The results were different from earlier studies [3] which were not done in army environment. Similarly, majority of

subjects in this study were not having frustration in relationships as causative factor for relapse in contrast to earlier study [30]. Based on the findings of our study, during psychoeducation and Cognitive Behaviour Therapy (CBT), handling positive and negative mood states and dealing with social pressures during therapeutic sessions and CBT should be focus of clinical attention. Self-help techniques like assertiveness training will go long way in improving positive coping skills to deal with relapse.

LIMITATION

It was a cross sectional study; hence no causality can be drawn. A follow up study would have provided us with more valuable knowledge about the longitudinal course of the illness. The study focused on soldiers who relapsed post treatment for Alcohol Dependence. A prospective case control study would yield more relevant information on the subject.

CONCLUSION

The reasons for first relapse after achieving a period of abstinence were mostly intrapersonal factors like feeling of sadness and good mood followed by interpersonal issues like someone offering a drink. Careful consideration is required in evaluating the reasons for 1st relapse after successful de-addiction treatment. Improving the handling of positive and negative mood states and addressing these reasons in therapeutic regimen will enable us to have a good intervention progrramme.

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