Volume 2 Issue 1,Jan to June 2016

Management of Alcohol Dependence with co-morbid Psychiatric Disorder

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Abstract

Co-morbidity of Alcohol dependence and mental disorders is very common presentation in our day today clinical practice. Co-morbid nature of illness poses a real challenge for mental health professionals in assessment and management of dual diagnosis patients. Here we present a case of 27 year old male who presented with history of alcohol dependence, sexual abuse in intoxicated state, repetitive sexual thought and guilt feelings, sadness of mood, decreased interest and interaction. The paper presents a comprehensive psychological assessment and psychotherapeutic management of the case using integrated approach to treatment that include various evidence based techniques of motivational enhancement therapy and cognitive behavior therapy. We also discussed the major challenges/barriers faced in the process and how to overcome those challenges.

Key words: Cognitive Behavior therapy, Integrated approach, Motivation enhancement therapy, co-morbidity

Introduction

Co-morbidity is defined as co-occurrence of two disorders in the same person, simultaneously or sequentially. The presence of Alcohol dependence with co-morbid psychiatric disorders is very common. The importance of co-morbidity implies in its effect on the course and prognosis of the illnesses. A high prevalence of co-morbidity of alcohol use disorder and psychiatric disorders has been consistently reported in epidemiological (Kessler et al., 1994; Wells et al., 1989; Bland., 1988; Andrews G, Slade T, Issakidis C et al., 2002) as well as clinical studies (Schuckit et al., 1997; Darke S & Ross J., 1997) from western countries. The research evidence has established the clinical relevance of co-morbidity as it is often associated with poor treatment outcome, increased risk of relapse, severe and prolonged illness course and increased burden of mental healthcare delivery system. A recent review of Indian studies on psychiatric co-morbidity in alcohol use disorder also reported mood disorders, psychotic disorders, anxiety disorders, personality disorder and sexual dysfunction as commonly associated diagnosis with alcohol use disorder (Singh & Balhara, 2016). We as mental health professionals often encounter such cases where co-morbidity makes the diagnosis as well as treatment complex. Here I am presenting a case that also became tricky as

well challenging due to the co-morbid nature of disorders.

Case Description

Mr. G is a is 27 years old male, educated up to 9th class, unmarried, belong to low SES and urban background presented with the chief complaints of alcohol abuse for past 12 years, repetitive sexual thought and guilt feelings for past 5 years, sadness of mood, decreased interest and interaction for past 3 years. He was apparently well 12 years back when he had to leave his studies due to financial constraints in the family. He started working as a salesman after discontinuing his studies to support his family. During that time, he found very little support from family and also lost his previous school friends. He would feel lonely in the evening after coming back from work so he joined a group of the boys in their neighborhood. One evening, one of his friends offered him some alcohol. He accepted that out of peer pressure and curiosity. He felt some kind of relief and relaxation from ongoing stress. Then he started consuming alcohol in company of his friends more often. Patient reported a strong desire and sense of compulsion to take the alcohol and also gradually increased in the amount of alcohol consumption to achieve the desired effect. He started consuming alcohol daily without fail. At times, he would steal money from his house for alcohol but later on he would feel guilty for the same. Many times he would think about leaving alcohol but could not resist his urge to have so. He also experienced withdrawal symptoms for alcohol like ghabrahat, palpitation, tremors, anxiety symptoms, sleep disturbances on discontinuation of alcohol or reduction in amount of alcohol.

Patient also reported repeated instances of sexual abuse from the age of 16 years by one of his friend who was older than him in age. Although these incidences had happened in the state of alcohol intoxication over which patient had no control .Still he assumed responsibility and felt guilty for the same. For past 5 years, he reported to have repetitive sexual thoughts that start after seeing other people around him. Whenever he interact with anyone, his attention would get focused on the genital area of the person which would then lead to recurrent thoughts about past experiences of his own sexual abuse. Most of the time he found himself to be preoccupied with these thoughts and feel distressed for the same. He would find these thoughts disturbing, irrational and completely unwanted. He would try to avoid

or resist these thoughts but would be unable to do so. As a result of these thoughts, he started to avoid people. He also started remaining alone at home and would scarcely engage in any meaningful conversation. He had stopped going to work. As reported by the informant that. Patient's mother expired due to renal failure 3 years back to whom he was closed to. Father reported that initial few months he was unable to accept the fact that his mother is no more. Subsequently he started feeling sadness of mood. He would not take interest in any pleasurable activity and would consume increased amount of alcohol. Family history revealed a significant history of alcohol abuse in father and depression in mother and elder brother. Mental Status Examination revealed anxious affect, preoccupation with sexual thoughts and depressive cognitions, with grade IV insight.

Method

Single case study design was used to assess the patient. The patient was assessed comprehensively using following tools.

Assessment

A detailed Psycho-diagnostic assessment was carried out and findings are shown in table 1

Table 1: Psychological Assessment, Rationale and findings

TEST ADMINISTERED	RATIONALE	FINDINGS
Sack Sentence Completion Test (SSCT)	To know the conflict areas	Severe conflict in family (father) area sex area (heterosexual relationships) and self area (fears and guilt feelings)
Draw a person Test (DAPT)	To know the psychopathology and self concept.	Feelings of inadequacy, lack of confidence, aggression, depressive conditions, rejection and need for affection, sexual conflict, obsession, anxiety, impulsivity, lack of ambition and passivity.
Beck Depression Inventory (BDI-II)	To assess the severity of depression.	Scores- 34, Severe level of depression.
Y-BOCS	To assess the severity and type obsessive and compulsive symptoms	Scores on obsession-21 (Moderate severity)
Rorschach Inkblot Test	To assess the personality structure	Limited kind of perception And stereotyped view of

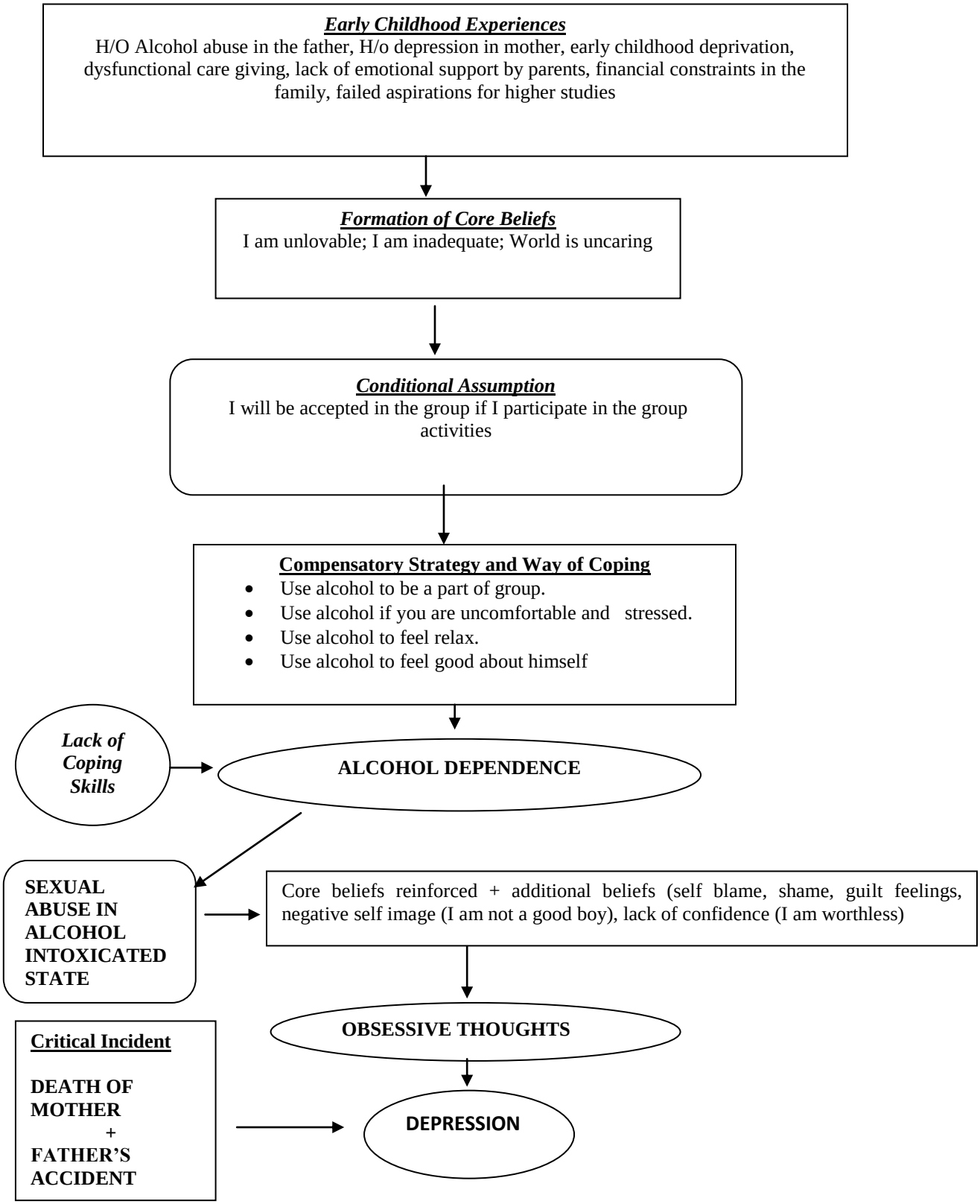
	and organization.	the world. Preoccupation with minute details. Difficulties in dealing effectively with other people and impaired interpersonal relations. Emotional deprivation, feelings of helplessness and lack of voluntary control in dealing with powerful instinctual urges.

PSYCHOLOGICAL FORMULATION

As we can see from the diagrammatic representation below that some childhood experiences like alcoholism in father, depression in mother caused early childhood deprivation, dysfunctional care giving, lack of emotional support by parents, financial constraints in the family and failed aspirations for higher studies. These experiences had contributed to the formation of core beliefs i.e I am unlovable, I am inadequate, world is uncaring. To counter that core beliefs patient developed a conditional assumption i.e. I will be accepted in the group if I participate in group activities. Lack of coping skills to deal with those core beliefs and ongoing stressors in the family led patient to use alcohol as a compensatory strategy or way of coping due to easy availability of alcohol with the development of some beliefs related to alcohol i.e use alcohol to be a part of the group, Use alcohol if you are uncomfortable and stressed., Use alcohol to feel relax, Use alcohol to feel good about himself. This later became an addiction and thus led to alcohol dependence. This alcohol dependence became a major contributing factor of sexual abuse done to the patent which further reinforced the existing core beliefs with additional beliefs related to self blame, shame, guilt, negative self image and lack of confidence and led to the formation of obsessive thoughts. In continuation with his obsessive thoughts, a critical incident in the form of mother's death and father's accident led to depression.

Volume 2 Issue 1,Jan to June 2016

Figure: 1 Psychological formulation



Therapeutic Process

An integrated approach was used by accommodating different techniques from motivation enhancement therapy (MET), supportive therapy and cognitive behavior therapy

Objectives of therapy:

Short term objectives:

- To ensure complete abstinence and symptom resolution.

***Long term objectives*:**

- Maintenance and relapse prevention with coping skills training

Initial phase

Initial phase of the treatment was focused upon the establishing rapport and connect empathically with the patient, explore more about his condition, goal setting and discussing about the psychological formulation of his illness.

Psycho-education and Goal Setting: Psycho-education session was focused on discussion about nature of illness and psychological formulation. Motivation assessment was carried out using readiness to change questionnaire. He was encouraged to ventilate his feelings and emotions about his experiences. Mutual goals' setting was done for therapy

Motivational interviewing & Activity Scheduling

Motivating enhancement therapy (MET) initiated by giving the feedback about the motivation assessment results that revealed contemplation stage of motivation. Patient was motivated by informing that you are at better motivation level as compare to other people. Therapist emphasized on client's responsibility for change and capability for change lie within the client.

Activity scheduling is a behavioral technique of CBT to manage passivity of depression. Patient was asked to engage himself in to some productive activities along with increased participation in ward activities with other patients.

Building phase of Motivation

Cost and Benefit analysis

Therapist encouraged the active involvement of the client in the identification of the problems caused by alcohol in the cost benefit analysis and tried to elicit the self motivational statement from the client by raising the client's awareness of the negative consequences of his drinking. In this

analysis, patient gave only one positive aspect of his drinking that he would feel nice after having a drink where as he reported many negative aspects of drinking. Therapist tried to prepare him to enter into frank discussion of change in order to reduce perceived discrepancy and regain emotional equilibrium.

Distraction techniques was taught to the patient after explaining the rationale by saying that it would help him reduce his preoccupation with sexual thoughts as well as distress associated with them. In distraction technique client is asked to count 20-1 backward counting whenever he would have the thoughts or he can engage himself in some activities like reading newspaper and watching TV. Therapist encouraged the patient to participate in the group meeting in the ward.

Decision matrix was reviewed by asking the patient to describe the benefits of change, disadvantages of continuing the use of alcohol. By using decision matrix, therapist assisted the patient to see accurately the consequences of drinking and to begin devaluing the perceived positive aspects of alcohol. Therapist's tried to shift the balance in favor of change. Therapist enhanced the self efficacy of the client by appreciating the client for his motivation.

Middle phase of the therapy:

Thought switching*:* A variant of thought stopping i.e thought- switching procedure was used. In which client was trained to dismiss the unwanted thought and substitute another thought in its place.

Ventilation, a technique of supportive therapy was used to address the issue of sexual abuse. The therapist encouraged the patient to ***ventilate*** his feelings and emotions related to those past experiences. The main focus of these sessions was addressing the client's feelings of guilt, and responsibility for the abuse and his beliefs related to that abuse by empathizing with the client.

Cognitive Restructuring was used to deal with the patient's beliefs about his own self and others. Therapist asked the patient to monitor his negative thoughts. Identified negative automatic thoughts were challenged by the therapist using verbal challenging and provided alternative views. Most of these thoughts were related to patient's feelings of inadequacy and low confidence in his ability to deal with the problems.

Positive self talk and Coping self talk was introduced to enhance the patient's self

efficacy and self esteem. It also helped the patient in dealing with the thoughts and feelings related to patient's inadequacy. Therapist prepared the flash cards of positive affirmations and asked the patient to verbalize it as home work assignment.

In the second phase of ***MET: strengthening the commitment*** to change. Therapist involved the father in the treatment process. Therapist asked the father to give his feedback about negative effects of drinking on the patient's life. At the same time, therapist asked the father to employ the support to the patient by commenting favorably on the positive steps taken by the patient to make a change in drinking. Therapist also tried to elicit the self motivational statement from father to facilitate the process of change in patient's behavior and to strengthening his commitment to change.

Terminal phase of therapy: focused on long term objectives of the treatment

Maintenance and Relapse Prevention

Assessment of High Risk Situation: Assessment of high risk situations was done. It involved the identification of events that typically precede the use of alcohol and the identification of the consequences which may reinforce or maintain that use. During the interview patient was asked to describe the all situations specific to them that had been frequently associated with heavy drinking, with strong urges to drink, or with difficulty resisting urges in the past. Patient reported financial stressors, family problems and peer pressure as the three high risk situations for lapse or relapse. After identification of high risk situation, therapist tried to enhance the coping skills of the patient.

Assertiveness training and Drink Refusal skills were used with the aim of enhancing the client's interpersonal effectiveness in social situations and would make him competent enough to handle the future high risk situations. Modeling and role plays were done in the session by creating the situation in the session to enhance the assertiveness of the patient. Session was also held on the management of craving using ***Stimulus control technique*** in which patient was asked to avoid those stimulus which provoke the drinking behavior.

Development of the Social Support Network of the client by increasing the patient's interaction within the family and to have a group of sober friends where he can share his feelings and to whom he can ask for help when needed. Patient was also

encouraged to be a member of a group which would help him in maintaining sobriety and to widen his social support network.

PHASE-3 MET

In phase -3 of the MET, therapist reviewed the progress and tried to enhance the motivation and commitment of the patient. Therapist educated the patient about relapse and lapse and how to handle it. Therapist expressed her confidence on patient's ability to deal with these situations in the future and tried to motivate him to take the responsibility. Therapist tried to prepare the patient for termination by increasing the time duration in between the session and giving all the responsibility on the client. It was done by appreciating his efforts and active involvement in the treatment.

Follow up and Outcome:

A total of 14 sessions were held with the patient. Eleven sessions were held during his inpatient stay and three sessions as follow up. He had significant improvement as he was maintaining abstinence for past 3 months after being discharged from the hospital. Improvement in sadness of mood and obsessive thoughts was also reported which was assessed during the post therapy assessment by using BDI-II and Y-BOCS. On BDI-II, patient obtained the score of 10, indicate minimal depression. On Y-BOCS, the scores on obsession come down to 10. A significant improvement was also observed in socio-occupational functioning of the patient as he started going to work and have got few sober friends. Booster sessions were planned for maintenance and relapse prevention.

Discussion

A number of different treatment approaches exist. The most common model of treatment for individuals suffering both alcohol use disorders and mental illness is sequential treatment. Commonly, the addiction is treated first, and once abstinence is achieved then the psychiatric symptoms are addressed. Alternatively, parallel treatment, in which a patient receives treatment for both addiction and mental illness simultaneously. Another evidence based approach to treat co-morbidity is integrated approach that has shown its effectiveness for managing substance use disorder co-morbid with anxiety or depression in a recent randomized control trial (Wüsthoff; Waal & Gråwe., 2014). Integrated approach was first developed in United States in 1989 (Minkoff

K., 1989) and with a purpose to offer a combine treatment to patients with substance use disorder with co-morbid mental disorder by the same therapist. This approach is comprehensive approach that use various evidence based techniques and focus on rehabilitation as well as harm reduction in such patients.

We also used integrated approach to manage the patient described above and the reason behind treating alcohol problem and psychiatric illness at the same time was its impact on the treatment outcome. Psychiatric symptoms affect a person's level of motivation to remain abstinent. At the same time as per our short term objectives of symptom resolution, we focused on the current issues of distress first and at the same time dealing with the alcohol dependence. A total of 14 sessions were held with the patient. Eleven sessions were held during his inpatient stay and three sessions were held in OPD follow up as booster sessions. The major obstacle in treating substance use lies in its nature of relapse and so here comes the role of regular booster sessions with the patient. As we all know that the ward stay is a very safe period for the patient to remain abstinent but the major test of maintenance of abstinence happens after going back to the same community of friends and same environment with same ongoing stressors. So it becomes important for the therapist to be in touch with patient's wellbeing and continue with booster session to enhance his coping skills to deal with high risk situations. Generally after getting discharged from the hospital, the patient would come for follow up to the treating doctor/psychiatrist for medication to manage withdrawal/craving however they lost follow up with therapist as they do not feel a need of the psychotherapeutic intervention or they do not want to be involved in to the therapy due to its time consuming nature. So to overcome this barrier we planned brief booster session with patient and encouraged him to be in therapy follow up by involving the treating psychiatrist to make sure that the patient would take booster session first and then get the medicine follow up and also encouraged family to share their concerns with the therapist and motivate patient to be in follow up.

The major challenges of treatment are being caused by the co-morbidity of alcohol dependence with depression, anxiety however to overcome this challenge we used symptom focused approach and target the most distressing part (guilt, shame of sexual

abuse) of illness first. Being a female therapist pause another challenge in rapport building with the patient. The major reason for improvement lies in patient's own level of motivation, continuous support from father and his self efficacious beliefs in his own ability. To conclude, integrated treatment approach is a need of hour for managing patients with co-morbidity.

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