Case report

Effectiveness of Psychosocial Intervention in the Management of Alcohol Dependence Syndrome with Poor Marital Adjustment: A Case Report

ABSTRACT

AIM:

Globally, it has been found that the mean lifetime prevalence of alcohol use is 80% and for alcohol use disorder (AUD) is 8.6%, and AUD has an adverse impact on an individual as well as on the person's family. In view of the same, we choose a case of alcohol dependence syndrome (ADS) to investigate the effect of long-term alcohol use on family dynamics, marital adjustment, interpersonal relationship, and motivational level of the individual with ADS, as well as the effectiveness of pre- and post- brief psychosocial intervention in the treatment outcome of the individual with ADS by involving his family and strengthening his interpersonal relationships.

PRESENTATION OF THE CASE:

The client had a history of alcohol use for 22 years. He was admitted to hospital in 2016 and diagnosed with alcohol dependence syndrome. He remained abstinent for the next 5–6 months after discharge, but had poor treatment compliance. For the past 2.5 years (2016–2019), the client again started drinking and the symptoms recurred. He was admitted there again on May 30, 2019. It was found that the prolonged alcohol use of the client had an adverse impact on his spouse's wellbeing and also on his interpersonal relationships with his parents and siblings. Further, it was found that the client had a lower level of motivation, poor adaptive patterns, inadequate social support, and poor marital adjustment.

DISCUSSION:

This study discovered a significant difference between pre- and post-psychosocial interventions in the management of ADS. After our intervention, the client has been doing well. His marital adjustment has increased with his improvement in quality of life, family dynamics, and adaptive patterns.

CONCLUSION:

It was found that psychosocial intervention with the person with alcohol dependence as well as his family is effective.

Keywords: *alcohol dependence, psychosocial intervention, psychiatric social work, marital therapy, motivational interviewing, family therapy, group therapy, relapse prevention*

1. INTRODUCTION:

Dependence on alcohol or other substances, and difficulty in controlling alcohol-taking behaviour in terms of its onset, termination, or level of use, despite clear understanding of the overtly harmful consequences of consuming it, is a chronic mental and behavioural disorder with relapse episodes.[1] Alcohol is one of the leading causes of death and disability.[2] 3 million deaths (5.3% of all deaths) every year result from the harmful use of alcohol.[2] 5.1% of the global burden of disease and injury is credited to alcohol.[2] It is estimated that the global mean lifetime prevalence of alcohol use is 80%, and the prevalence of alcohol use disorder (AUD) is 8.6%,[3] with 4.1% of the Indian population suffering from AUD[4]. Alcoholism not only has a negative impact on the individual with mental illness and non-communicable diseases, but it also has a negative impact on the lives and well-being of other family members, including the spouse, who frequently suffers from intense psychological trauma. [5,6] Alcoholism invites economic hurdles, burden, poor marital satisfaction, guilt, codependence, poor coping skills, lack of motivation, legal problems, dysfunctional family dynamics, damage of social reputation, major physical and emotional health problems, stressful interaction patterns, domestic violence, low self-esteem, separation and divorce, in life and family.[6,7] Studies have also shown that the role of family members, their attitudes and belief in the treatment, is critical in maintaining the individual with ADS's abstinence, compliance, and recovery.[5,6] Leaving the family members untreated will limit the effectiveness of the treatment by not accepting the family system as support for change for the individual.[8] Psychiatric social work intervention has an effective role to play in the wellbeing of family members, treatment, and recovery process of the individual by focusing on building motivation for change and strengthening commitment to change.[8-10]

This study signifies the impact of psychosocial intervention on the marital adjustment of the spouse of the person with ADS. It will explore the need for multidimensional psychosocial intervention in addition to medication in the management of ADS to improve the interpersonal relationships of the individual and to achieve complete abstinence and compliance by involving family members.

2. PRESENTATION OF THE CASE:

The index client, 42 years old, married, a businessman, educated up to class VI, from a nuclear Bengali-speaking Hindu family of lower socio-economic status hailing from a rural area, without any significant past psychiatric or medical history and a well-adjusted premorbid personality, presented with complaints

of regular alcohol intake, feeling sad, loss of interest in work for the last 7 years, anger outbursts for the last 4 to 5 years, low self-confidence, restlessness, and becoming anxious for the last 3 years, which were insidious in onset, with the course being continuous and progressively deteriorating. The client first drank alcohol (100 ml) at the age of 20 with his friends. Though he was not a regular drinker initially, his alcohol intake increased gradually (200 ml/day) due to family, financial, and occupational stressors (his business shop built on government property was demolished, and he was cheated of Rs. 4.00 lakh in a financial scheme). For the past 8 years, he had been consuming about 2–5 litres/day of country liquor nearly regularly. Gradually, he became an easily irritable person with frequent anger outbursts. In 2016, his spouse took him to the Institute of Psychiatry (IOP). He was admitted and treated there for 12 days. A diagnosis of alcohol dependence syndrome (F10.2) [ADS] was made.[1] He remained anstinent for the next 5–6 months after discharge, but had poor treatment compliance. For the past 2.5 years (2016–2019), the client again started drinking and the symptoms recurred. For the last 8–9 months, he only did some work to secure money to buy alcohol. Due to his further worsening condition, his spouse took him to the Institute of Psychiatry (IOP), Kolkata, and he was admitted there again on May 30, 2019. Personal history revealed that the client was a planned baby, was shy as a child, and was an average student. He had a favourable attitude towards siblings, relatives, and friends, and he had a few friends in his later childhood, but had many friends and used to participate in all social and religious gatherings during his adulthood. The client was married 16 years ago. Things started to get affected gradually after his alcohol intake increased. They have been unable to become parents due to his spouse's medical complications. The client had a good sexual life initially, but with time he lacked interest. The Mental Status Examination revealed that the client had a depressed mood, death wishes, increased reaction time, depressed cognition (ideas of helplessness, hopelessness, and worthlessness), reduced contraction and attention, with poor judgment.

2.1 Family Genogram:

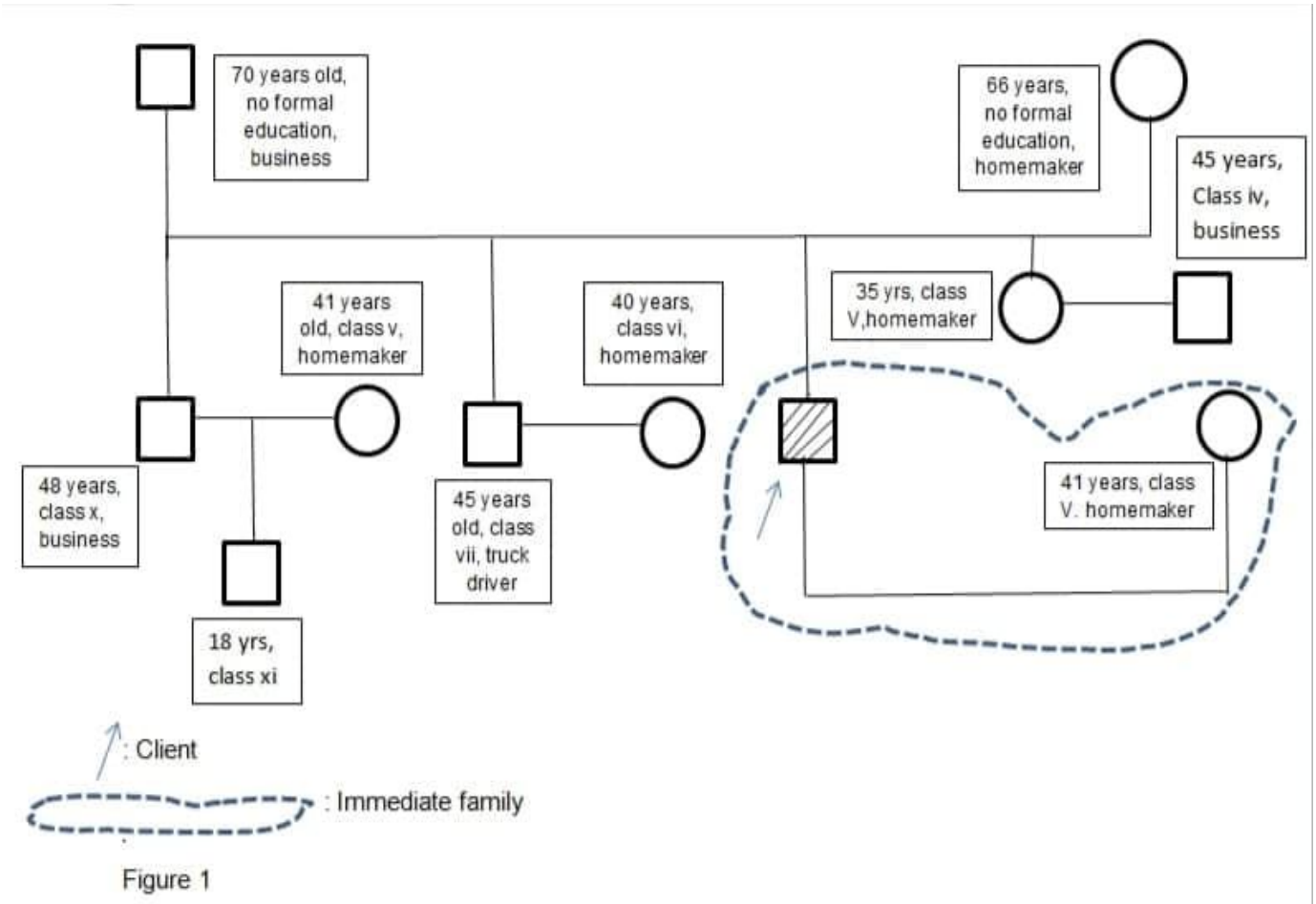

Fig 1: Family Genogram

2.2 Family Interaction Pattern: The client was abusive physically, emotionally and verbally towards his spouse. The client and his spouse had strained relationship with his parents and siblings since their love marriage. In a small residential compound, the client's parents and siblings are staying together under the same roof, whereas the client and his spouse are living together in another house in the said compound. Their relationships with other family members deteriorated with the increase in alcohol consumption by the client. He also used to misbehave with his parents and siblings. His family disliked his spouse working outside.

2.3 Family Dynamics: The boundary was found to be diffused as the client's alcohol dependence made the family dysfunctional. Leadership was found to be democratic, along with the absence of a spousal subsystem. The client was the nominal leader and his spouse was the functional leader. Role multiplicity and role burden were present as the client's spouse used to do most of the household work by her. Direct communication was present between the client and his spouse. Indirect and switchboard

communication (mostly via distant relatives) was present between the client's immediate family, parents and siblings. The noise level was high in the family, along with chaos, guilt, extreme arguments or extreme silence, and blame. Positive reinforcement was rarely present in the family and there were an absence of "we" feelings, poor stress management patterns, poor problem-solving ability, and poor coping skills along with prevalent negatively expressed emotions.

2.4 Psychosocial Diagnosis: [1]

Z56 Problem related to employment and unemployment

Z63 Problem in relationship with spouse or partner

Z63.1 Problem in relationship with parents and in-laws

Z63.2 Inadequate family support

Z63.8 Other specified problem related to primary support group

Z72 Problems related to lifestyle

Z72.1 Alcohol use

Z72.3 Lack of physical exercise

Z72.4 Inappropriate diet and eating habits

Z73.3 Stress, not elsewhere classified

2.5 Evidence-based brief psychiatric social work intervention

Psychosocial intervention in this case includes the following brief interventions towards the client and family over 18 sessions.

2.5.1 Admission Counseling & Psychoeducation: For a better understanding of the illness, psychoeducation was given to the client about the illness and its comorbidities. A brief education about the client's illness was given to the client's spouse. Admission counselling was provided, the hospital's rules and regulations were explained, and the client and his spouse were also informed of the mode of visit. The treatment plan and procedure for the client and hospital facilities were informed. Requests and suggestions from the client and his spouse were enquired about the above and noted. The client's right as a person with mental illness was also discussed.

2.5.2 Family assessment & intervention: A family assessment was done with the client's spouse to intervene on psychosocial issues in the family and to understand the level of knowledge of mental illness due to harmful use [1] of alcohol. It was found that the client's spouse had no clear knowledge of the client's illness and the impact of his prolonged use of alcohol. It was also revealed that she had an adverse impact due to the client's alcohol dependence, and she had developed symptoms of anxiety and depression, codependency, marital dissatisfaction, crying spells, prolonged absence of engaging in pleasurable and self-rewarding activities, and low self-esteem. The Marital adjustment test (MAT) scale was administered.[11] Psychoeducation about ADS was provided to her. The cycle of addiction was also explained. Supportive intervention was imparted to her. Stress management techniques and coping skills

were also taught to her. The importance of treatment adherence for the client and family; the role of the caregiver or family member in the treatment process of the client, maintaining abstinence, early warning signs, prevention, and recovery of the client were discussed. Repeated reassurance was given to her. Externalization of interests was suggested. Further sessions focused on her wellbeing were continued.

2.5.3 Motivational Enhancement Therapy (MET): MET, also referred to as motivational interviewing, is a time-bound, systematic therapeutic approach of motivational psychology that aims to bring about rapid change by utilizing one's own internal resources.[12] The index client was introduced to it. His perception of alcohol use was discussed. A baseline assessment was done to understand the drinking pattern, abstinence period, relapse triggering factors, locus of control, interpersonal relationship problems, coping patterns, and client's attitude towards drinking. Following, the RCQ (Readiness to Change Questionnaire) was administered and it was found that the client was in contemplation stage.[13] Interventions were made according to his needs by following MET principles.[13] The cost and benefit analyses of taking and quitting alcohol were discussed with worksheets. Therapist boosted the self-esteem of the client during each session. The expectations and reality of client's life, harmful impact of substance abuse on family, social, professional, and personal life, and the addiction cycle were also discussed. The therapist also appreciated the client's strengths and efforts, empowered him to minimize his weaknesses, and gave him feedback.

2.5.4 Relapse Prevention Strategies: The relapse prevention model of Marlatt and Gordon (1985) suggests that high-risk situations, poor coping skills, outcome expectancies, effort of abstinence violation, lifestyle factors, and urges and cravings, can contribute to relapse.[14] The therapist helped the client identify the high-risk situations and taught him the skills to manage them; also taught him learn anger management, coping skills, distraction techniques, handling stressors and peer influences, recognizing urges and triggers, the importance of engaging in physical exercise, and craving management skills. Relapse prevention worksheets were given. Warmth and repeated reassurance were provided to the client.

2.5.5 Social Group Work: A group is a gathering of people who have similar problems and are encouraged to share their experiences.[15,16] Group therapy emphasizes on behavioural change communication (BCC), ensures compassionate support and encouragement towards individuals and reduces feelings of isolation.[15,16] The index client had face-to-face interaction with all the members of the group and engaged in group activities. He understood that substance abuse is a mental illness and is treatable. He also understood the myths and facts related to substance use. The group helped him to strengthen his coping skills by learning decision-making and problem-solving skills; learning new ways to deal with the problem; and breaking the cycle of addiction. He learnt from the success stories of the recovery of others. His motivational level was enhanced and strengthened. He felt connected to others there. His level of awareness about the problems had increased.

2.5.6 Marital or Couple Therapy: Marital or Couple Therapy is a form of psychotherapeutic treatment modification that focuses on patterns of interaction and communication between two people in order to

achieve a higher level of relationship satisfaction.[17] The index client and his spouse were engaged briefly in Behavioural Couple Therapy (BCT) (an evidence based successful treatment method for alcohol use disorder), which tries to build support for abstinence for the person with substance use with the help of his spouse through daily 'contracts' and shared rewarding activities with acceptance and change.[18] Therapists emphasized on emotional-focused therapeutic approach, which helped them to improve their bonding and to understand and change patterns that lead to disconnection. Further, the therapist focused on Gottman's principles for making relationships work and explained the same to rebuild trust and commitment. [19] A few BCT worksheets and relationship enhancement worksheets were also given to the client and his spouse, along with making the client realize his spouse's need for a child who may be adopted.

2.5.7 Pre-discharge Counseling: To strengthen the client's post-hospital life and wellbeing, the therapist focused on the following areas in the session: signs and symptoms of the illness; etiology; prevalence rate; prognostic factors of the illness; medication compliance; early warning signs of relapse; and relapse prevention.

2.5.8 Home Visit: The Index client had problematic relationships with his parents and siblings, who had no clear understanding of the nature of his chronic illness. They even refused to participate in the treatment process and wellbeing of the client. To address this, therapists visited the client's home and imparted psychoeducation to the client's family, emphasized their key role in treatment, abstinence, and the importance of cohesiveness and support for him. The therapist explained to them the principle of reward and reinforcement and its importance in the client's recovery and maintenance. Therapists also requested that they accompany the client in follow-up sessions.

2.5.9 Discharge Counseling: The session was attended by the client and his spouse. Therapists emphasized on the importance of treatment adherence by providing a medication log-sheet, advised supervised medication, maintaining abstinence, productive activity scheduling, externalization of interest, dealing with stigma, adopting a healthy lifestyle, the importance of primary and secondary support, encouraged the client to join ***Alcoholics Anonymous*** [20] which helps in maintaining abstinence, and coming in for regular follow-up on a monthly OPD basis with the given worksheets to monitor progress.

2.5.10 Follow-up sessions: After discharge, the client along with his spouse and older nephew, went for follow-up in the next 11 months. Feedback was taken. The professional life of the client was discussed. AUDIT (Alcohol Use Disorder Identification Test) and MAT were administered, and family dynamics were assessed. [11,21] The client was found to be in good health, following advice and instructions till last visit. The spouse of the client was doing better. An interpersonal relationship with parents and siblings was improved.

Table 1: Pre-, Mid-, & Post- intervention Assessment to measure level of Alcohol Dependence

Scale	Maximum Score	Pre- intervention assessment	Mid- intervention assessment	Post- intervention assessment

		Score	Impression	Score	Impression	Score	Impression
The Alcohol Use Disorder Identification Test (AUDIT)	40	38	Severe level of alcohol dependence	23	Moderate-Severe level of alcohol dependence	07	Lower level risk of alcohol dependence

Table 2: Pre- & Post- Intervention Assessment to determine level of Marital Satisfaction / adjustment of Spouse of the person with ADS

Scale	Maximum Score	Pre- intervention assessment		Post- intervention assessment	
		Score	Impression	Score	Impression
Marital Adjustment Test (MAT)	158	52	Lower level of marital adjustment	121	High level of marital adjustment

3. DISCUSSION:

This study discovered a significant difference between pre-and post-psychosocial interventions in the life and wellbeing of a person with ADS and his family. After our intervention, the client gained insight regarding his illness, and a change in lifestyle has been noticed. His level of motivation was enhanced. His treatment compliance was better and he was maintaining abstinence till last visit. There was no violence in the family, and marital adjustment had increased. Symptoms of psychological trauma were not noticed in the spouse of the client. The client's family had a better understanding of his illness and their role in his treatment and recovery. Family interaction patterns had improved. Further, significant improvement had found in the quality of life, family dynamics, and coping skills of the client. The client started working and earning well. He started supporting his spouse in household activities. The burden and negative expressed emotions was reduced promisingly in the family. Many other researchers, including Borah and Ali (2016), Harikrishnan and Ali (2016), and Rajan, Thomas, and Dhanasekarapandian (2016), supported the findings of this study, which revealed that group therapy, MET, relapse prevention model, and family intervention are effective and necessary approaches in psychosocial intervention in the treatment of people with ADS and their families.[8-10] This study also found support from O'Farrell and Clements (2012) as they found the role of marital and family therapy in strengthening the coping mechanisms of the family affected by alcohol use and the role of BCT in increasing abstinence rates and improving the relationship of couple.[22] There have been no noteworthy

studies discovered that contradict the findings of this study and discourage the treatment procedure used in this case.

4. CONCLUSION:

It can be concluded that treatment and rehabilitation of persons with ADS and their families has been a key area of the psychiatric social work profession. Medications combined with psychosocial intervention are essential in the management of ADS to bring the person back into mainstream life and society. As a result, we are of the view that all person with ADS after suggesting anti-craving agents should be referred with family members for psychiatric social work (PSW) intervention at the earliest. The individual should be referred further to a suitable self-help support group, like Alcoholics Anonymous, in due course by the therapists. There is a great need to engage in community-based awareness and programmes for early identification, treatment, and prevention of alcohol use by involving stakeholders. Policies and programmes should be designed by policy makers to reduce alcohol availability in the community and for other relevant actions to support health professionals, children and families.

CONSENT: As per international standard or university standard written informed consent of the client and family has been collected and preserved by the author(s).

ETHICAL APPROVAL: As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

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