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Original Research Article

Psychiatric profile of patients with alcoholism

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ABSTRACT

Background: The overall personality is related to the treatment outcome. Hence for successful treatment and management of alcohol dependent cases, it is essential to understand their personality. Objective was to study the psychiatric profile of patients with alcoholism.
Methods: Present cross sectional hospital based study was conducted for six months in department of psychiatry, Institute of mental health, Hyderabad, a tertiary care psychiatric facility. This 600 bedded hospital has a daily outpatient clinic and provides inpatient care. Alcohol dependence syndrome and uncomplicated withdrawal state patients only were included in the present study. Age less than 18 and more than 60 years, patients with mental retardation, patients with personality disorders were excluded.
Results: Majority of subjects belongs upper low socioeconomic status 57.50% (n=23), 36 (90%) were Hindus, two (5%) were Muslims and two (5%) were Christians. 42.5% (n=17) were illiterate, 22.5% (n=9) were having primary school education. 12.5% (n=5) were single, 87.5% (n=35) were married. 77.5% (n=31) were unskilled, 17.5% (n=7) were semiskilled, and 5% (n=2) were skilled. Maximum were from rural areas (67.5%) and 32.5% were from urban areas. self-injurious behavior is female and males are same 25% (n=5). Majority of males in the high-risk level of severity of alcoholism has banging head against something, to the extent that caused a bruise to appear type of behavior.
Conclusions: Majority alcoholics were from low social classes, were illiterate, were married, unskilled workers. Hence these group people should be paid proper attention to prevent the occurrence of alcoholism among them.

Keywords: Alcoholism, Psychiatric profile, Withdrawal state

INTRODUCTION

It is thought that alcoholism or dependence on alcohol is related to personality disorders. They are considered to be emotionally immature. They might become alcoholic as they are hurt. They have feeling of insecurity and feel inadequate. They are unable to fulfil their roles and hence may become dependent on alcohol. But as a rule of thumb, not all with such personality will become alcoholic. So, it is thought that personal maladjustment may be a risk factor. The overall personality is related to the treatment outcome. Hence for successful treatment and management of alcohol dependent cases, it is essential to understand their personality.[1] Some believe that alcoholism and anxiety disorders go hand in hand. They exist as co-morbidity. Many studies have also uncovered this association. The studies report that this association is complex and multifaceted. Hence the management is complicated and difficult if the co-morbidity exists.[2]

Alcohol consumption in India is a socially and culturally acceptable in the community to permissible extent. Previously Indians used to have alcohol occasionally and as means of ritual. But now a day it has become a regular affaire. Hence eyebrows are raised on the present situation. There is a tendency of excessive drinking and number of alcohol dependence is increasing year by year. In the last 15 years, proportion of people using alcohol below the age of 21 years has increased from 2% to more than 14%.[3]

Alcoholics tend to harm self and others. Abuse can lead to self-injurious behavior. They become anti-social often. Alcoholism is directly involved in many criminal situations. Studies of these alcoholics in relation to their demographic and social characteristics are required. Such studies help to throw light on identifying risk factors and identify those who are prone to develop such behaviors. Hence present study was conducted to study the psychiatric profile of patients with alcoholism.

METHODS

Cross sectional hospital based study was conducted for six months in department of psychiatry, Institute of mental health, Hyderabad, Andhra Pradesh, India, a tertiary care psychiatric facility. This 600-bedded hospital has a daily outpatient clinic and provides inpatient care. Alcohol dependence syndrome and uncomplicated withdrawal state patients only were included in the present study. Age less than 18 and more than 60 years, patients with mental retardation, patients with personality disorders were excluded.

A total of 40 patients were included in the present study. They were diagnosed as having alcohol dependence syndrome using ICD-10 coding. After their verbal informed consent, data was collected from them. ICD-10 criteria used to diagnose the alcoholism group, total subjects were 40 (Male 20, Female 20). For the purpose of this study, the word 'alcoholism' is used to indicate alcohol dependence syndrome (ICD-10). Alcohol use disorders identification test (AUDIT) was applied and score noted for each patient. Detailed history was recorded. The tools used were the alcohol use disorders identification test (Audit), deliberate self-harm inventory, International Classification of Diseases (ICD-10), WHO 1992.[4]

The alcohol use disorders identification test (AUDIT)[4]

The alcohol use disorders identification test (AUDIT) incorporates questions about the quantity and frequency of alcohol use in adults. AUDIT compares favourably with other instruments in detecting risky drinking. Developed by the World Health Organization (WHO) for use in primary care settings to identify persons whose alcohol consumption has become hazardous or harmful has proven useful among medical, surgical, and psychiatric inpatients; in emergency rooms; in DWI offenders; criminals in court, jail and prison; workers encountered in employee assistance programs and industrial settings. AUDIT is relatively free of gender and cultural bias. Time to administer was 2 minutes.

Total score interpretation

A score of 8 or more is associated with harmful or hazardous drinking. A score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Table 1: Severity score.

Score	Severity
0-7	Low risk
8-15	Hazardous risk
16-19	Harmful risk
≥20	High risk

RESULTS

Table 2 shows socioeconomic status of the study population. Majority of subjects belongs to upper low socioeconomic status 57.50% (n=23), middle socioeconomic status 25.0% (n=10), low socio economic status 10.0% (n=4) and upper middle socioeconomic status 7.5% (n=3).

Table 2: Socioeconomic status of study population.

Socio economic status	Number	Percentage
Class II	3	7.5
Class III	10	25
Class IV	23	57.5
Class V	4	10
Total	40	100

Table 3: Religious status of study pop.

Religion	Number	Percentage
Hindu	36	90
Muslim	02	05
Christian	02	05
Total	40	100

Table 3 shows religious status of the study population. 36 (90%) were Hindus, two (5%) were Muslims and two (5%) were Christians.

Table 4: Literacy status of study population.

Literacy status	Number	Percentage
Illiterate	17	42.5
Primary school	09	22.5
High school	08	20
Intermediate	02	05
Graduate and above	04	10
Total	40	100

Table 4: Marital status of study group.

Marital status	Number	Percentage
Single	05	12.5
Married	35	87.5
Widowed	00	00
Separated	00	00
Total	40	100

Table 5: Occupational status of study group.

Occupational status	Number	Percentage
Unskilled	31	77.5
Semi skilled	07	17.5
Skilled	02	05

Table 5 shows marital status of the study population. 12.5% (n=5) were single, 87.5% (n=35) were married and none were widower and separated/divorced. Table 6 shows occupational status of the study population. 77.5% (n=31) were unskilled, 17.5% (n=7) were semiskilled, and 5% (n=2) were skilled.

Table 6: Residential status of study population.

Residence	Number	Percentage
Rural	27	67.5
Urban	13	32.5

Table 7 shows residential status of study population. Maximum were from rural areas (67.5%) and 32.5% were from urban areas.

Table 7: Self-injurious behavior in the study group.

Self injurious behavior	Male		Female		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Yes	05	25	05	25	10	25
No	15	75	15	75	30	75
Total	20	100	20	100	40	100

Table 9: Self-injurious behavior and severity of alcoholism.

	Male					Female					Total
Type of SIB	LR	HZ	HF	HR	T	LR	HZ	HF	HR	T	
Cutting*	-			1	1	-	-	-	3	3	4
Burned with a cigarette	-	-	-	-	-	-	-	-	-	-	-
Burned with a lighter	-	-	-	1	1	-	-	-	-	-	1
Carved pictures**	-	-	-	-	-	-	-	-	-	-	-
Banged***	-	-	-	2	2	-	-	1	1	2	4
Punched****	-	-	-	1	1	-	-	-	-	-	1
Total				5	5			1	4	4	10

*Cut your wrist, arms, or other area(s) of body (without intending to kill yourself); **Carved pictures, designs, or other marks into your skin; ***Banged your head against something, to the extent that you caused a bruise to appear; ****Punched yourself or punched another item (i.e., wall, etc.), to the extent that a bruise or cut appeared. [SIB-Self-injurious behaviour, LR-Low risk, HZ-Hazardous, HF-Harmful, HR-High-risk, T-Total].

Table 8 shows self-injurious behavior in female and males are same 25% (n=5).

Majority of males in the high-risk level of severity of alcoholism has banging head against something, to the extent that caused a bruise to appear type of behavior. Majority of females in the high-risk level of severity of alcoholism has cutting type of behavior (Table 9).

DISCUSSION

Majority of subjects belongs upper low socioeconomic status 57.50% (n=23), middle socioeconomic status 25.0% (n=10), low socio economic status 10.0% (n=4) and upper middle socioeconomic status 7.5% (n=3). 36 (90%) were Hindus, two (5%) were Muslims and two (5%) were Christians. 42.5% (n=17) were illiterate, 22.5% (n=9) were having primary school education, 20% (n=8) studied up to high school level, intermediate level literacy was seen among 5% (n=2) and 10% (n=4) were graduates. 12.5% (n=5) were single, 87.5% (n=35) were married and none were widower and separated/divorced. 77.5% (n=31) were unskilled, 17.5% (n=7) were semiskilled, and 5% (n=2) were skilled. Maximum were from rural areas (67.5%) and 32.5% were from urban areas. self-injurious behavior is female and males are same 25% (n=5). Majority of males in the high-risk level of severity of alcoholism has banging head against something, to the extent that caused a bruise.

Cook S et al studied association between socio demographic factor and alcohol drinking patters among working males.[5] They studied 1005 males aged 25-29 years. Self-administered questionnaires were used. They reported that as the literacy status increased, the level of alcoholism decreased, which is in accordance to the findings of the present study. Upper social classes and higher amenities were also inversely associated with alcoholism.

Pillai A et al studied association between low social class and alcohol use disorders.[6] They also studied the alcohol drinking patterns. They also studied the adverse outcomes among male drinkers. They found that the rural people consumed more dangerous quantities of alcohol than urban residents. Similar finding has been reported in the present study. The higher drinking quantity was associated with low level of education and low social class. We also report the similar findings. Older age, low education, being separated were found to be risk factors for more frequent heavy drinking.

Haw C et al studied 40 patients as per ICD-10 coding having alcohol dependence.[7] They studied the incidence of deliberate self-harm among them before and after the treatment. They compared this group to other patients with deliberate self-harm without alcohol users. They found that patients in the DSH alcoholic group were older, males, unemployed, living alone, disabled, sick, and more with a past history of DSH. The prevalence of aggression, anger and impulsivity was more among this group of DSH alcoholic patients. The prevalence of co-morbid psychiatric disorder was 92.5% among DSH alcoholic patients.

Cook S et al investigated the relationship between acute alcohol dysfunction on employment status.[8] They found that there was no effect on future employment status due to volume of ethanol consumed. They also noted that non-beverage alcohol consumption was associated with loss of regular paid employment. This was mainly attributed to acute alcohol related dysfunction. Thus, they concluded that acute alcohol related dysfunction was an important determinant for stability in the job of people.

Haw C et al reported that there is an increased risk of DSH among those who are alcoholics.[9] They studied 17,511 events of DSH among 10,414 patients. Alcohol disorder was more common in males as compared to females. They concluded that around the time of DSH, there was a statistically significant increase in the alcohol consumption.

Pompili M et al suggested that those with alcohol dependence should be screened for psychiatric disorders.[10] As alcohol use is increasingly becoming an important risk factor in suicide. This happens through impulsiveness, disinhibition, and impaired judgment.

Makhija NJ et al reported that in adolescent suicide cases, alcohol use is an important risk factor.[11] That it causes through disinhibition, alcohol myopia, and impaired judgment. They also doubt the role of genetic factors. These genetic factors lead to mood disorder and susceptibility for stress.

Sher L stated that alcohol use is significantly associated with suicides.[12] They observed that as much as 40% of alcoholics attempted suicide. They identified various risk factors like being male, age more than 50 years, unemployment, living alone, lack of social support, heavy drinking, family history of alcoholism.

Lejoyeux M et al noticed that continued use of alcohol leads to psychiatric disorders.[13] These disorders are anxiety, depression and personality disorders. This is also related to increased risk of suicides. They suggested that only after two weeks of complete alcohol withdrawal should the antidepressant treatment be initiated.

Al-Sharqi AM et al found that suicidal ideation was present among 50.7% of cases, self-injurious behavior was present in 6.9% of cases.[14] Combined self-injurious behavior and suicidal ideation was seen among 13.1% of cases. They found that hopelessness, refusing a safety plan, perceived burden on family, sexual abuse were the risk factors.

Ekramzadeh S et al investigated the prevalence and risk factors for suicidal ideation.[15] They concluded that suicide ideation was more among physically ill and hospitalized patients.

Millwood IY et al found that the prevalence of alcohol drinking was 76% in males and 36% in females.[16] Among them, 33% males and 2% of females were consuming regularly on a weekly basis.

CONCLUSION

Majority alcoholics were from low social classes, were illiterate, were married, unskilled workers. Hence these group people should be paid proper attention to prevent the occurrence of alcoholism among them.

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