

ALCOHOL USE DISORDERS**Mr. Rajeesh KG* | Dr. Rajesh G Konnur****** Research Scholar in Himalayan University, Itanagar in Arunachal Pradesh, India.****Associate Professor, Kurji Holy Family Hospital College of Nursing, Patna, Bihar, India.***ABSTRACT**

Mental stress, Anxiety and mood disorders are highly co-morbid with alcohol dependency; and are usually more severe when they happen together than when they present alone. Alcohol use in the attempt to reduce anxiety (self-medication hypothesis) has often been used as an explanation for the high co-morbidity rates between anxiety, depression and alcohol use disorders. Alcohol-use disorders are related with depressive episodes, severe anxiety, insomnia, suicide, and abuse of other drugs. Continued heavy alcohol use also shortens the onset of heart disease, stroke, cancers, and liver cirrhosis, affects the cardiovascular, gastrointestinal, and immune systems.

Key Words: *Anxiety, alcohol, behaviour.*

ABOUT AUTHORS:

Author, Mr. Rajeesh KG is a research scholar in Himalayan University, Itanagar, Arunachal Pradesh, India.



Author Dr. Rajesh G Konnur Associate Professor, KHFHCON, Patna, Bihar, India. He has been awarded Bhartiya Shikha Ratan award – 2007 for ‘individual achievements and national development’ by the economic for health and educational growth.” New Delhi. Shikha Bharati award – 2007 for Excellency in education by Indian achievers forum. New Delhi.

INTRODUCTION:

Alcoholism, also known as alcohol use disorder (AUD), is a broad term for any drinking of alcohol that results in mental or physical health problems. According to the American Medical Association, "alcoholism is an illness characterized by significant impairment that is directly associated with persistent and excessive use of alcohol. Impairment may involve physiological, psychological or social dysfunction." The word alcohol comes from the Arabic "Al Kohl," which means "the essence."

Anxiety and mood disorders are highly co-morbid with alcohol dependency; and are usually more severe when they co-occur than when they present alone. Alcohol use in the attempt to reduce anxiety (self-medication hypothesis) has often been used as an explanation for the high co-morbidity rates between anxiety, depression and alcohol use disorders. Alcohol-use disorders are associated with depressive episodes, severe anxiety, insomnia, suicide, and abuse of other drugs. Continued heavy alcohol use also shortens the onset of heart disease, stroke, cancers, and liver cirrhosis, by affecting the cardiovascular, gastrointestinal, and immune systems.

The reality is that alcohol is often abused because it initially offers a very tantalizing promise. With mild intoxication, many people become more relaxed. They feel more carefree. Any preexisting problems tend to fade into the background. Alcohol can be used to enhance a good mood or change a bad mood. At first, alcohol allows the drinker to feel quite pleasant, with no emotional costs. As an individual's drinking progresses, however, it takes more and more alcohol to achieve the same high. Alcoholism is a complex disease, which has been misunderstood and stigmatized. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), Alcohol Dependence and Alcohol Abuse are among the most common mental disorders in the general population, with about eight percent of the adult population suffering from Alcohol Dependence and five percent from Alcohol Abuse. (Mascot C, 2016)

Studies have revealed that alcohol consumption is associated with more than 60 types of disease and injury⁶. The prevalence of co-morbidity of depression and alcohol use disorders (AUD) has been demonstrated in a number of researches Depression in an alcohol-dependent person has been reported to not only lower the resolve to resisting alcohol use, but may also lead to use of alcohol to relive the depressive symptoms. It is important to understand the significance of co-occurrence of depression and alcohol use disorders since this may explain why majority of cases relapse after treatment for alcohol dependence. In addition it may explain why antidepressants have been shown to moderately benefit patients with both depression and alcohol use disorders (Kuria M et al, 2012).

Alcohol is probably the only legal and the commonest substance of abuse after nicotine in most regions of the world. Alcohol use started with prehistoric ages and has taken place throughout the past millennia; however, health outcomes of its use became a subject of concern only since last few decades. World Health Organization (WHO) estimates that there are about 2 billion people worldwide who consume alcoholic beverages and 76.3 million have a diagnosable alcohol-use disorder (16). The same report estimates 1.8 million annual deaths (3.2% of total) and 58.3 million (4% of total) of disability adjusted life years (DALYs) attributed to alcohol globally. Alcohol constitutes the largest risk factor for DALYs lost in middle income countries and the third largest in all income group countries (Neupane S P, 2011).

Although India is regarded as a traditional "dry" country, it is the dominant producer of alcohol in the South-East Asia region (65 percent) and contributes to about 7 percent of the total alcohol beverage imports into the region. More than two thirds of the total beverage alcohol consumption within the region is in India. There has been a steady increase in the production of alcohol in the country, with the production doubling from 887.2 million liters in 1992-93 to 1,654 million liters in 1999-2000 and it was almost 2300 million liters by 2006-07. India is experiencing a massive increase in alcohol Consumption. This is coupled with the initiation age decreasing on an alarmingly. The recorded market and consumption levels are still very low as compared to the global standard. The illicit market consumption is far more than legal sales. Country liquor is a distilled alcoholic beverage made from locally available cheap raw material such as sugarcane, rice, palm, coconut and cheap grains, with alcohol content between 25-45 percent. Common varieties of country liquor are arrack, desi sharab and toddy. Illicit liquor is mostly produced in small production units with raw materials similar to that used for country liquor. With no legal quality control checks on them, alcohol concentration of illicit liquor varies (up to 56 percent). Adulteration is quite frequent, industrial methylated spirit being a common adulterant, which occasionally causes incidents like hooch tragedies. Cheaper than licensed country liquor, illicit liquor is popular among the poorer sections of the population. In many parts of India, illicit production of liquor and its marketing is a cottage industry with each village having one or two units operating illegally. (Loyi T 2009)

Repeated observations have documented that more than 50 percent of all drinkers in India, satisfy the criteria for hazardous drinking. The people who indulge in hazardous drinking follow a pattern. They drink alone; drink predominantly IMFL and drink more than five standard drinks per occasion. Alcohol use is strongly associated with expectations of disinhibiting and violence, especially among men, which 'legitimizes' 14 male drunkenness and violence. Patterns of alcohol consumption are probably more important than per capita levels of alcohol use in predicting whether people will experience problems with their drinking, making them better indices of the likelihood of harm in the population (Loyi T 2009).

Based on alcohol consumption experts classify the population into an abstainer, someone who does not consume alcohol, a social drinker, someone who drinks occasionally that too in limited quantity, a binger, someone who is an abuser of alcohol, who drinks large quantity of alcohol per session very frequently and a dependent, a person who is alcohol dependent and is in the later stages of chronic alcoholism (The News Minute, 2015).

According to the World Health Organization's global status report on alcohol and health, vast majority of Indians, 75% of men and 95% of women above the age of 15 abstain from alcohol consumption. So by doing a per capita consumption of alcohol calculation, the large number of abstainers in the country, the denominator of the calculation, help drastically diminish the intensity of the problem. But instead, if one does a per drinker consumption of alcohol, the magnitude of the alcoholism problem in India takes on gigantic proportions. The minority of men who drink, end up consuming on an average a whopping 32.1 liters of pure alcohol per year. This is more than double the alcohol consumption of a drinker in European countries where alcohol consumption is an integral part of their daily food habit. So the problem with alcoholism in India is that the minorities, who drink, drink far too much and/or consume drinks with high alcohol content. There is no data readily available on what percentage of Keralites consume alcohol. It might be safe to assume that like the rest of the country, in Kerala too the vast majority of the population is abstainers. A life time of observation will tell me that the real problem in Kerala, the booziest state in India, too is that those who drink, drink far too much. So the real problem we are facing and the one we need to solve is the problem of binge drinking (The News Minute, 2015).

Alcohol consumption is a major public health issue in the world. Understanding regional differences in its use will help in planning for better interventions. A study was conducted with the objective to assess and compare prevalence, patterns and harmful use of alcohol among college students in Arunachal Pradesh and Kerala. A self-administered questionnaire survey done among college students in the selected districts of Arunachal (352 students) and Kerala (703 students). Scientific sampling method (stratified sampling using class divisions as strata) was used to select students. Questionnaire sought information on demography, patterns of alcohol use, alcohol use in family and among friends, beliefs and perceptions regarding alcohol, the CAGE questionnaire and tobacco practices. Univariate, bivariate and multiple logistic regression analysis were done using SPSS version 17.0. Result revealed that prevalence of alcohol use among college student was 60.5% and 22% in Arunachal and Kerala respectively. Students having problem drinking was 32.3% and 8.1% in Arunachal and Kerala respectively. Majority (81.2%) of males and 38.6% of females used alcohol in Arunachal Pradesh. In Kerala 46.1% males and 5.9% females use alcohol. Mean age of initiation was earlier (11years) in Arunachal compared to Kerala (16 years). Most students (70.6%) in Arunachal got initiated into alcohol at own home and 44.9% continue to drink at home whereas in Kerala these are 23.8 and 16.1 percent respectively. In Arunachal family members were present at initial drink in majority (63.3%) whereas it was only 24.5% in Kerala. Amount of pocket money, use among parents and siblings, discussions on harm of alcohol in family and school/colleges had an impact on use of alcohol. Study highlights increased prevalence of alcohol among college students and emphasizes on regional difference in the practices and beliefs attached alcohol. Future interventions on alcohol menace should be made in tune with its regional differences ((Loyi T, 2009)

The distribution of psychiatric illnesses including those related to alcohol use is universal and the burden is heavy. A mixed occurrence of two or more of these illnesses heralds challenges to reaching early diagnosis and institution of appropriate treatment- even among those who seek help. Failure to curb the problems rigorously and early in course of the disease increases risks of adverse outcomes in terms of physical, mental and social wellbeing as so happens in familial and professional fronts. Today, almost three quarters of the global burden of neuropsychiatric disorders occur in low- and middle-income countries. The dimensions of disease epidemiology may vary by regions. This is especially true in case of psychiatric morbidities where socio-cultural attribution may modulate relationships between the disorders. Psychiatric co-morbidity is a co-occurrence of more than one psychiatric diagnosis in the same individual at the same time, sometimes owing to diagnostic misclassification of underlying single pathology. Alcohol abuse and alcohol dependence, together called alcohol use disorders (AUD), are often associated with co-morbid conditions, nicotine dependence being the

most common. This is followed by mood and anxiety disorders which are also quite often co morbid with alcohol-use disorders. Major depression is a cluster of symptoms of low mood and anhedonia as defined by American Psychiatric Association. The co-occurrence of major depression in alcohol-use disorders is rather a rule than just chance (Neupane S P, 2011).

Clinical and epidemiological studies have shown substantial co-occurrence of anxiety disorders with alcohol use disorders. A possible explanation for the high co-morbidity rates is the 'self-medication hypotheses. Although at first the use of alcohol may decrease anxiety symptoms, later on it promotes persistent and excessive use via negative reinforcement. In patients with dual diagnosis, agoraphobia and social phobia precede the development of alcohol use disorders, whereas generalized anxiety disorder and panic disorder are more frequently diagnosed after the onset of the drinking problem. Based on the frequent co-occurrence of anxiety disorders with alcohol use disorders and the negative influence of other co-morbid psychiatric disorders on the outcome of treatment of alcohol dependence, it has been stated that co-morbid anxiety disorders predict poor outcome of alcoholism treatment (Schade Loes A A, 2003).

Clinical trial with pre-/post measurements was conducted to determine the prevalence of depression among alcohol-dependent persons before and after alcohol detoxification and rehabilitation. The Composite International Diagnostic Interview (CIDI) and WHO-ASSIST (Alcohol Smoking Substance Use Identification Screening Test) were administered to 188 alcohol-dependent persons at intake and after six months. A researcher-designed socio-demographic questionnaire was also administered at intake. The result shows that the prevalence of depression at intake before detoxification was 63.8% (120 participants). Six months after detoxification and completion of rehabilitation the prevalence of depression was 30.2% (47 participants). There was a statistically significant reduction (P value 0.000) in the prevalence of depression at six months during which period the participants had undergone community-based detoxification and rehabilitation for alcohol dependence. At posttest, depressed participants had a statistically significant craving for alcohol. The researchers concluded that alcohol dependence is associated with major depression and it is important to screen for depression and evaluate to determine the treatment needs during detoxification and rehabilitation (Kuria M, 2012).

Alcohol dependence and alcohol abuse or harmful use cause substantial morbidity and mortality. Alcohol-use disorders are associated with depressive episodes, severe anxiety, insomnia, suicide, and abuse of other drugs. Continued heavy alcohol use also shortens the onset of heart disease, stroke, cancers, and liver cirrhosis, by affecting the cardiovascular, gastrointestinal, and immune systems. Heavy drinking can also cause mild anterograde amnesias, temporary cognitive deficits, sleep problems, and peripheral neuropathy; cause gastrointestinal problems; decrease bone density and production of blood cells; and cause fetal alcohol syndrome. Alcohol-use disorders complicate assessment and treatment of other medical and psychiatric problems. Standard criteria for alcohol dependence—the more severe disorder—can be used to reliably identify people for whom drinking causes major physiological consequences and persistent impairment of quality of life and ability to function. Causes include environmental factors and specific genes that affect the risk of alcohol-use disorders, including genes for enzymes that metabolise alcohol, such as alcohol dehydrogenase and aldehyde dehydrogenase; those associated with disinhibiting; and those that confer a low sensitivity to alcohol. Treatment can include motivational interviewing to help people to evaluate their situations, brief interventions to facilitate more healthy behaviors, detoxification to address withdrawal symptoms, cognitive-behavioral therapies to avoid relapses, and judicious use of drugs to diminish cravings or discourage relapses (Schuckit M A, 2009).

CONCLUSION

Kerala, God's own country, is one of the highest consumers of alcohol in India. Alcohol drinking patterns in India evolved over centuries. In ancient period, India had an ambivalent drinking culture. Establishment of East India Company led to liberalization of liquor market in India, leading to an increase in alcohol use. Kerala was one of the states where alcohol consumption has been traditionally high. Per capita consumption of alcohol in Kerala is 8.3 L, according to Alcohol and Drug Information Centre (ADIC), India. Twenty percent of the general population of state uses alcohol. Intensity of drinking also is more in Kerala (14% of population consume alcohol daily), as compared to the other states of the country (where on an average, 11% drink on a daily basis). The investigator also had observed patients with alcohol use disorder in hospitals and de-addiction centers as a part of mental health nursing practical during under graduation and post graduation. He found that the patients with alcohol use disorders have several psychiatric disorders which put their life under distress. Thereby he personally intended to conduct a study to identify the mental health problems in context of depression and anxiety.

REFERENCES

1. Kuria M, Ndetei M D, Obot I S (2012). The Association between Alcohol Dependence and Depression before and after Treatment for Alcohol Dependence. *ISRN Psychiatry*. 6
2. Loyi T (2009). Prevalence and patterns of alcohol use among college students: comparing scenario in Arunachal Pradesh and Kerala. Achutha Menon Centre for Health Science Studies Sree Chitra Tirunal Institute for Medical Sciences and Technology Thiruvananthapuram, Kerala..
3. Schuckit M A (2009). Alcohol-use disorders. *The Lancet*. 373 (9662). 492-501.
4. The News Minute, (2015) <http://finalmile.in/behaviourarchitecture/why-prohibition-will-not-solve-keralas-alcoholism-problem>.