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PREVENTION OF RELAPSE IN ALCOHOLISM

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ABSTRACT:

Introduction

The modern scientific concept defines the alcohol dependence as a chronic relapsing disorder that can be cured. Relapse prevention programs are part of the interventions based on scientific evidences. (1) The recovery process is marked by abstinence episodes interrupted by slips and relapse. The studies on relapse show that their proper management is closely linked to high risk situations management. (3)

Motivation of the study

Attempting to prevent relapse

The object of the study

Preventing the relapse in patients under study after the treatment for *delirium tremens*

Method

For this purpose, 50 of the patients treated of *delirium tremens* have been included in the next study. The patients have been divided into two groups: a group which continued the treatment with tiapridal tablets of 100 mg / 3 tablets / day, and the second group which received no treatment (control group), but accepted to come for examination on the dates set and undergo the required investigations.

As a result of the study performed to prevent relapse, we have found that there are better results in the case of the group treated with tiapridal than in the case of the control group.

The medication treatment and monitoring are not enough though. Today, the US Institute of Medicine Committee for the Study of Treatment and Rehabilitation Services for Alcoholism and Alcohol Abuse (Institute of Medicine, 1990), admits that the specialized treatment is just a necessary and vital part in the treatment of alcoholism. Association of psychological techniques such as (1, 4):

- Counselling;
 - Cycle of change;
 - Motivational interview;
 - Cognitive behavioural therapy, etc.
- is required.

Keywords: Recovery, medication treatment, psychotherapeutic treatment, monitoring

REZUMAT:**Introducere**

Concepția științifică modernă definește dependența de alcool ca o boală cronică, vindecabilă, cu recăderi. Programele de prevenire a recăderilor fac parte din intervențiile bazate pe evidențe științifice. (1) Procesul de recuperare este marcat de episoade de abținere întrerupte de alunecări și recăderi. Studiile pe tema recăderilor atestă faptul că managementul adecvat al acestora este strâns legat de managementul adecvat al situațiilor, de mare risc. (3)

Motivația studiului

Încercarea de prevenire a recăderilor

Obiectivul studiului

Prevenirea recăderilor pentru pacienții aflați în studiu după tratamentul pentru *delirium tremens*

Metoda

În acest scop, 50 dintre pacienții la care s-a efectuat tratament pentru *delirium tremens* au fost incluși în studiul următor. Pacienții au fost împărțiți în două grupe. Un grup care a continuat tratamentul cu tiapridal tablete: 100 mg / 3 tablete / zi și al doilea grup care nu a primit tratament (grupul de control), dar care a acceptat să se prezinte la control la datele stabilite și să efectueze investigațiile cerute.

În urma studiului efectuat pentru prevenirea recăderilor, constatăm că, în cazul grupului tratat cu tiapridal, se obțin rezultate mai bune față de grupul de control.

Tratamentul medicamentos și monitorizarea nu sunt însă suficiente. Astăzi, Comitetul Institutului de Medicină al S.U.A. pentru Studiul Tratamentului și Reabilitării Serviciilor pentru Alcoolism și Abuz de Alcool (Institute of Medicine, 1990) recunoaște că tratamentul specializat este doar o parte necesară și vitală a tratamentului alcoolismului. Este necesară asocierea unor tehnici psihologice, cum ar fi (1, 4):

- Consilierea;
- Ciclul schimbării;
- Interviul motivațional;
- Terapia cognitiv-comportamentală etc.

Cuvinte-cheie: recuperare, tratament medicamentos, tratament psihoterapeutic, monitorizare

We have also chosen a pharmacological method in order to prevent relapse, taking into account that, as we have said, Voila Hospital is an acute psychiatric hospital. Every individual has undergone a brief counselling session on coming out from withdrawal.

For this purpose, 50 of the patients treated for delirium tremens have been included in the next study. The patients have been divided into two groups: a group which continued the treatment with tiapridal tablets of 100 mg / 3 tablets / day, and the second group which received no treatment (control group), but accepted to come for examination on the dates set and undergo the required investigations.

INCLUSION CRITERIA

The patients who were included in this study were people who acknowledged their problem and wanted to give up drinking alcohol.

The patients with values on Reisberg Scale who show a moderate and slight cognitive impairment.

The visits were made monthly up to 6 months, then at 9 and 12 months. Data analysis has been performed at 6, 9 and 12 months.

Exclusion criteria

Persons that did not want to give up drinking alcohol

Patients with moderate to severe cognitive impairment on Reisberg Scale

Persons with epileptiform seizures

Relapse prevention (1)

The modern scientific concept defines alcohol dependence as a chronic relapsing disorder that can be cured.

Substance use disorders illustrate to the highest degree the biopsychosocial concept.

Thus, on the one hand, the initiation and maintenance of use are based on biological (e.g.: the genetic determined vulnerability in case of alcoholism), psychological (personality structure, the degree of frustration tolerance) and social (values of the group of equals, substance accessibility) factors.

Similarly, healing in case of an addiction represents not only giving up the addictive substance but also major changes in the lifestyle, in the way of passing time, in the circle of friends, new capabilities to maintain the abstinence, changes regarding the dynamic of intrapsychic processes (awareness, expression of emotions and needs, and a slow recovery of the cerebral function and of other organs affected by the toxic action of alcohol are observed at the biological level).

Therefore, the recovery process must take into consideration all these factors and address the medical (detoxification, treating the co-morbidities), social (financial needs related to finding a job or a place of residence), and psychological needs.

Relapse prevention programs are part of the interventions based on scientific evidences (1).

The recovery process is marked by abstinence episodes interrupted by slips and relapse. The studies on relapse show that their proper management is closely linked to the management of high risk situations.

There are two behavioural response options in a high risk situation.

In the first situation, the person has a proper response or manner of coping, which leads to the improvement of that person's confidence in the ability of coping with such situations, fact that determines a reduced probability of slipping or relapsing.

In the latter situation, the persons has an improper response, which leads to the diminishing of the feeling of personal efficiency.

Analysis of recurrence at 6, 9 and 12 months respectively depending on the allocated intervention (CHMEI Alcohol Use).

We have applied two methods of analysis, depending on data availability: mainly, an analysis of the patients who have adhered to the study protocol (per protocol), being included only the patients with available data at all times. Thus, at 6 months we have had available data from all 50 patients included in the second stage of the study, randomly on tiapridal and controls, respectively. At 9 months there were available data from 43 patients (22 on tiapridal and 20 controls), and at 12 months there were available data from 38 patients (20 on tiapridal and 18 controls).

The statistics used was the Mantel-Haenszel test, which can estimate the odds-ratio (the ratio between the cases of abstinence and of recurrence, subsequently reported for the two therapeutic interventions), the confidence intervals 95% and the statistical significance value.

It is noticed that the only statistical significant difference ($p = 0.005$) is for the analysis at 6 months, which estimates an odds-ratio of 10.615 tiapridal vs. control. It is worthy of noting that an OR value >10 is considered to be very powerful from the clinical significance point of view, indicating significantly higher abstinence rates at 6 months for the population treated with tiapridal. At 9 and 12 months, there were no statistically significant differences between the two arms of the study both in PP and ITT analyses (with imputation for missing data), OR being < 2 (modest clinical signification).

As seen in the tables at 6 months (Tab. I and Tab. II), the number of the abstinent patients in the first group is 23 (92 %), compared to 13 (52 %), in the second group.

	Abstinent	Occasional use	Abuse	Addicted	Giving up on the study	Total
Patients	23	2				25
Percentage	92%	8%				

Table I: *Analysis of recurrence at 6 using CHMEI Alcohol Use Scale*
CMHEI Scale at 6 months
Treatment with TIAPRIDAL

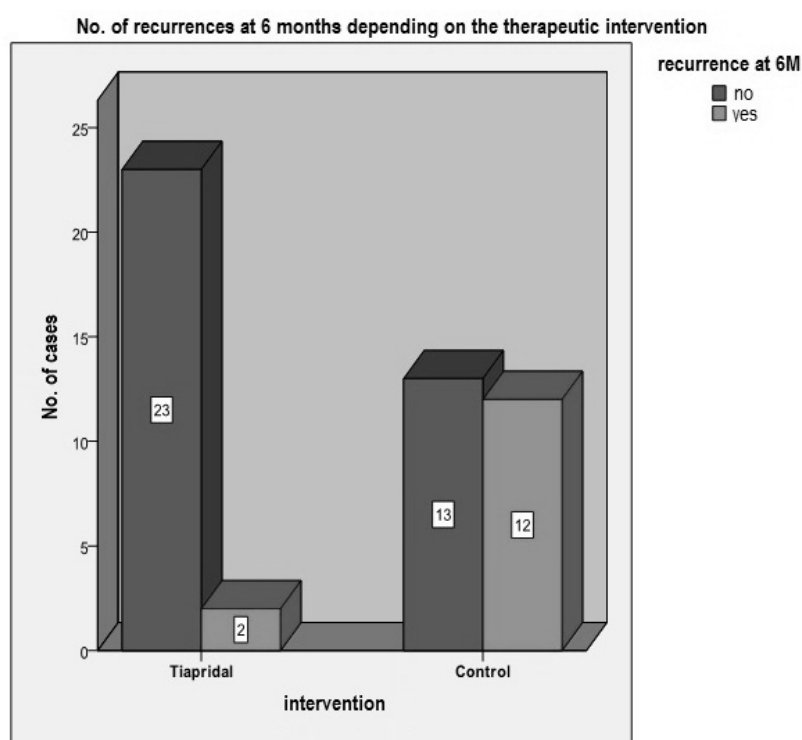
	Abstinent	Occasional use	Abuse	Addicted	Giving up on the study	Total
Patients	13	7	5			25
Percentage	52 %	28 %	20 %			

Table II: *CMHEI Scale at 6 months. Control group*

At 6 months, there were 2 patients (8 %) with occasional use of alcohol in the first group.

There were 7 patients with occasional use of alcohol (28 %) in the second group.

As for the alcohol abuse, there was no patient in the first group, whereas there were 5 patients (20 %) in the second group (Fig. 1).

Fig. 1: *No. of recurrences at six months depending on the therapeutic intervention*

Bar chart indicating the cases of abstinence and recurrence respectively at 6 months, in the comparison between the two groups of study (treated with tiapridal and control respectively). The chances for abstinence are 10.61 times greater in the case of the treatment with tiapridal. The analysis has been performed for the patients who have adhered to the study protocol.

Mantel-Haenszel Test: Odds-ratio abstinence/recurrence tiapridal vs. control: 10.615 (95 % CI: 2.05 – 54.95), $p = 0.005$

At 9 months (Tab. III and Tab IV) the results are closer together, although a large number of abstinent is found in the first group 12 (48 %), compared with 9 in the second group (36 %).

	Abstinent	Occasional use	Abuse	Addicted	Giving up on the study	Total
Patients	12	7	3		3	25
Percentage	48 %	28 %	12 %		12 %	

Table III: *Analysis of recurrence at 9, using CHMEI Alcohol Use Scale*

CMHEI Scale at 9 months
Treatment with TIAPRIDAL

	Abstinent	Occasional use	Abuse	Addicted	Giving up on the study	Total
Patients	9	3	6	2	5	25
Percentage	36 %	12 %	24 %	8 %	20 %	

Table IV: CMHEI Scale at 9 months. Control group

It is noted, though, that the number of patients with alcohol abuse is larger in the second group 6 (24 %) that represents the control group compared to 3 in the first group (12 %). Also, the number of those who had given up on the study is larger in the second group – 5 patients (20 %) compared to 3 patients (12 %). (Fig. 2)

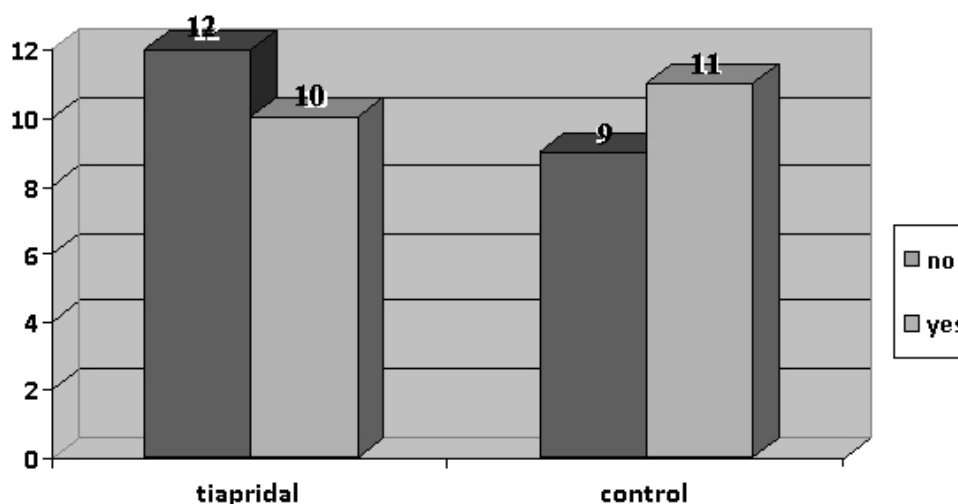


Fig. 2: Bar chart indicating the cases of abstinence and recurrence respectively at 9 months, in the comparison between the two study groups (treated with tiapridal and control respectively)

The chances for abstinence are 1.6 times greater in the case of the treatment with tiapridal, insignificantly both clinically and statistically. The analysis has been performed for patients who have adhered to the study protocol.

Mantel-Haenszel Test: Odds-ratio abstinence/recurrence tiapridal vs. control: 1.6 (95 % CI: 0.48 – 5.33), $p = 0.648$

After 12 months of study (Tab. V and Tab. VI) it is found that the number of the persons remained abstinent is larger in the first group – 8 (32 %), compared to the second group – 5 patients (20 %).

	Abstinent	Occasional use	Abuse	Addicted	Giving up on the study	Total
Patients	8	4	7	1	5	25
Percentage	32 %	16 %	28 %	4 %	20 %	

Table V: CMHEI Scale at 12 months. Treatment with TIAPRIDAL

	Abstinent	Occasional use	Abuse	Addicted	Giving up on the study	Total
Patients	5	1	4	8	7	25
Percentage	20 %	4 %	16 %	32 %	28 %	

Table VI: CMHEI Scale at 12 months. Control group

The number of relapses is not necessarily larger in the second group, but it is found that on each analysis date the number of ones with severe disorders, abuse and addiction is larger in the second group.

Also, the number of the ones giving up on the study is larger in the second group – 7 patients (28 %), compared to the first group – 5 patients (20 %).

The chances for abstinence are 1.73 times greater in the case of the treatment with tiapridal, insignificantly both clinically and statistically. The analysis has been performed for patients who have adhered to the study protocol. Mantel-Haenszel test: Odds-ratio abstinence/recurrence tiapridal vs. control: 1.73 (95 % CI: 0.44 – 6.79), $p = 0.657$.

No. of recurrences at 12 months depending on the medication in the study

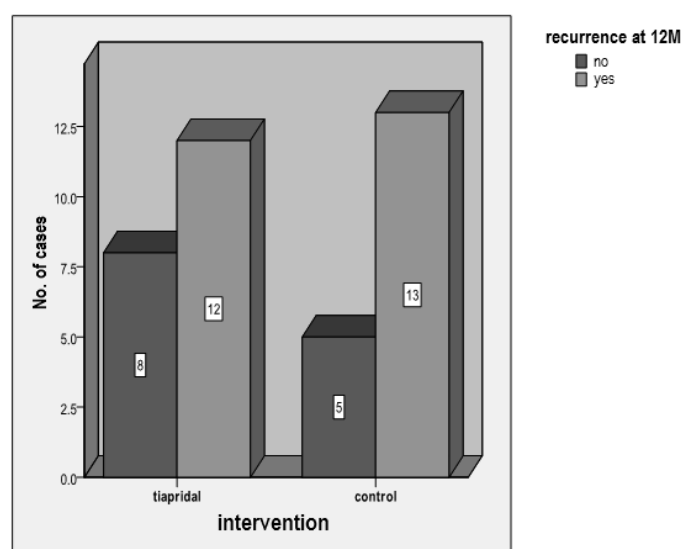


Fig. 3: Bar chart indicating the cases of abstinence and recurrence respectively at 12 months, in the comparison between the two study groups (treated with tiapridal and control respectively)

The medication treatment and monitoring are not enough, though. Today, the US Institute of Medicine Committee for the Study of Treatment and Rehabilitation Services for Alcoholism and Alcohol Abuse (Institute of Medicine 1990), admits that the specialized treatment is just a necessary and vital part of the treatment of alcoholism. Association of some psychological techniques such as (1.2) is required:

Counselling represents one of the necessary steps in a therapeutic intervention program in addiction. It starts with the presumption that every person suffering from addiction or being in high risk situations needs outside support to resolve multiple issues generated by the addictive behaviour or its pre-existence.

Another method refers to the cycle of change, the motivational interview.

Each and every one's existence is determined by the decisions made in different moments during in lifetime. There is a complex mix of biological, psychological and social factors (family, friends, and community) at the basis of these decisions.

These factors determine the possibility that an individual will chose to initiate, maintain and adhere to a certain strategy on long-term, strategy that aims at a change, in other words the motivation of that individual (Miller and Rollnick, 1991). Thus, the motivation is closely related to the process of personal change and development. In the area of substance dependence, the motivation plays an extremely important role and is at the basis of numerous decisions of changing use behaviour taken by the clients in the absence of treatment.

DECISIONAL BALANCE

It represents a useful tool in exploring the client's ambivalence and in facilitating decision making and consolidating.

The classical decisional balance described by Janis and Mann 1977 presents the decision as a process of cognitive weighing of advantages and disadvantages of change, wherein the change takes place when the person becomes conscious of the fact that the disadvantages exceed the advantages. Strictly speaking, the balance consists of the exploring the positive and negative effects of use behaviour alongside the client – both on short-term and long-term, as well as exploring the advantages and disadvantages of behaviour change. It is useful that the balance should initially be written by the therapist during the session and then by the client as homework. It is important that it constitutes a personalized tool, containing the client's phrases, and not interpersonal phrases from the specialized literature. The balance constitutes a radiography in "the here and now" and it may lean either way every day, the client being able to always add new advantages or disadvantages depending on the level of exploring and clarifying ambivalence.

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The author declares that she has no potential conflicts of interest to disclose.

REFERENCES:

1. Prelipceanu, D., Mihăilescu, R. (2005): NonA nonB variants in the binary typology of alcoholics, Addictive Disorders & Their Treatment, Vol. 4.
2. Gorski, Terence T. and Miller, Merlene et all. Counselling for Relapse Prevention. Herald House-Independent Press, Independence, MO, 1982.
3. Committee on Alcoholism and Addictions, Group for the Advancement of Psychiatry, Report No.142, Addiction Treatment, Avoiding Pitfalls – A Case Approach, American Psychiatric Press, Washington D.C., 1998.
4. Cartwright A. K. Are Different Therapeutic Perspectives Important in the Treatment of Alcoholism? British Journal of Addiction, 1981.