DOI: 10.26717/BJSTR.2017.01.000289

Shiva Raman Pandey. Biomed J Sci & Tech Res

BIOMEDICAL Journal of Scientific & Technical Research

ISSN: 2574-1241

Case Report Open Access

"The Psychopathological Craving": Cross-cutting through the Psychosocial Aftermath of the De-Addiction Process

Sareeta Behera[1] and Shiva Raman Pandey[2*]

[1]*Doctoral Researcher in Psychology, State Autism Appellate Board Member, India*

[2]*Founder and CEO, e Wellness Expert, MIMS Ardendale, India*

Received: July 31, 2017; **Published:** August 21, 2017

***Corresponding author:** Shiva Raman Pandey, Founder and CEO, e Wellness Expert, MIMS Ardendale, Kannamangala, Whitefield, Bangalore, India

Abstract

The pangs of an addiction often lead to fatal life outcomes. Its gradual transition from a regular behaviour, habituation to unavoidable craving and obsessive addiction reflects how a certain thing or aspect can become an inseparable entity of man's life. Addiction towards something can breach the thin borders between the triad of use, misuse and abuse. Although the former can have certain positive impact, however misuse or abuse of something is bound to lead to unfathomable physical, psychological, personal as well as societal level drudgery and despair. Severe addiction also has been reported to be one of the most significant contributors of crime, harming behaviour, suicide or eventual death. The de-addiction process comes as a ray of hope to fight against addiction and overcome the odds. However, the de-addiction process has to be administered under professional supervision and extreme care. The present clinical presentations reflect two case studies depicting both the affirmative as well as flip sides of the de-addiction process. The two cases stand as strong guidelines of practice, ethics and how de-addiction can have both positive and lethal outcomes depending on the management modalities and psychosocial support.

Keywords : Alcoholism; Alcohol Use Disorder; Alcohol Dependence; Depression; Suicide; Deaddiction; Withdrawal Symptoms

Introduction

Since time immemorial, the practice of intoxicating oneself has been a prevalent practice across different latitudes and longitudes of the world. Whether it is due to being a part of a lavish party or a mode of overcoming pain or stress; whether due to peer pressure or a traditional customary, the entire world has been a witness to alcohol use, habituation, dependence as well as abuse since ages and decades. In medical terms, the pathological use of alcohol leading to adverse effects has been considered as "Alcohol Use Disorder". Litterell and Jill [1] opine that Alcohol Use Disorder is denotes any drinking of alcohol that leads to serious physical and mental health problems. In layman terms, alcohol use disorder is often referred to Alcoholism. It was previously divided into Alcohol Abuse and Alcohol Dependence [2]. In a comparison documented between the Diagnostic Statistical Manual i.e. the DSM-IV and V editions [3], the psychopathology of alcohol use disorder has been comprehensively defined. It states that, [4] "alcoholism is said to exist when two or more of the following conditions is present: a person drinks large amounts over a long time period, has difficulty cutting down, acquiring and drinking alcohol takes up a great deal of time, alcohol is strongly desired, usage results in not fulfilling responsibilities, usage results in social problems, usage results in health problems, usage results in risky situations, withdrawal occurs when stopping, and alcohol tolerance has occurred with use."

Effect Approximation, Prevalence and Epidemiological Factors

The Global Status Report on Alcohol and Health by the World Health Organization (2014) has stated that the world comprises of 208 million, approx 4.1% of adults suffering from Alcohol Use Disorder. And the number of deaths due to it is 3.3 million or 5.9% of the entire world population. The significant causational factors include interplay of both genetic and environmental aspects starting from personal problems, stress, and depression to family, culture, and peer pressure and so on [5]. More so, according to the World Health Organization worldwide evidence reports, and if left untreated Alcohol Use Disorders can lead to severe physical, psychological and social negative impact like:

i. Mental Illness
ii. Wernicke-Korsakoff Syndrome
iii. Foetal Alcohol Spectrum Disorders
iv. Damaged Liver and Liver Failure
v. Irregular Heartbeat
vi. Certain Cancers

vii. Financial Loss

viii. Death

Alcohol Use Disorders have seen the worst clinical scenarios and co-morbidities across all life dimensions if not managed before it's too late. It is imperative to control, manage and prevent the "booze time-bomb" before figments of populations get wiped away due to it.

a. Case Scenarios and Clinical Presentations: Mr G. was in his mid-40s when he was admitted to the Intensive Care Unit of a Private Mental Healthcare Hospital due to excessive alcohol intoxication, severe vomiting, abdominal cramps and fleeting loss of consciousness. He was imparted with the first-line medical treatment at the outset and then shifted to the Psychiatric Ward for further psychiatric and psychological interventions.

b. Age of Onset and Clinical Progression: Drinking episodes of Mr G started when he entered into his college. Performance pressure and peer pressure first initiated the drinking and gradually it changed into a habit with due course of time. He reported of abusing alcohol incessantly after heartbreak, during his exams and as a respite from depression. However, there was a honeymoon phase in between when he had completely quit drinking habits after his marriage and becoming a father. His habits and clinical alcohol use disorder began when he met his ex online and some of his batch-mates again at a party. The memory of past life experiences triggered his alcohol abuse again. The relapse was even stronger with high levels of alcohol intake, non-adherence to alcohol safety regimes and difficulty from restraining even after the constant motivation by his wife and children. Conditions became worse when he started beating his wife and his physical health started deteriorating.

c. Management and Outcome: After intensive first-line medical treatment, Mr G was shifted to the psychiatric ward. At the outset, he showed denial towards the psychological treatment and reflected minimal level of insight towards his present critical nature of conditions. With appropriate pharmacotherapy and psychological interventions, he gradually quit drinking. Psychological interventions began with Psycho-Education about alcoholism and being non-judgemental towards the information and thoughts shared by him. With subsequent behaviour therapy, contingency models, stress management and relaxation technique his conditions improved significantly. In particular, Mr G. showed remarkable recovery when he was imparted with music therapy based relaxation sessions, JPMR techniques, depression therapy and positive self auto-suggestions.

d. Outcome: After 6-7 months of regular intensive psychopharmacological treatment and intensive psychological therapies including interpersonal and family therapies/support Mr G. became completely free of alcohol dependence and abuse. More so, he became a part of the Alcoholics Anonymous (AA) Support Groups in his area. He is an active advocate and peer support member inspiring many people to quit alcohol and lead a meaningful life.

e. Case 2: A 23 yrs old man who got married during his teenage and got HIV infected, Mr T got victimized by alcohol abuse and over-dependence since his preteen years. He stayed in a migrant slum area of the town and had been an observant of alcohol abuse, domestic violence and sexual abuse by his father and other members of the community since his early childhood years.

f. Clinical Progression: Mr T began abusing alcohol and got overly dependent on it when he was tested HIV positive. He belonged to the Lamani Community where the confidentiality of his HIV status was somehow breached and he was abandoned by the other members of the community. He, his wife and small children lived in a thatched house in the outskirts of the slum area. He was a driver and earned his living to the extent he could meet just the bare necessities of his family. He used to take off from work due to his degrading health issues and the aggravating episodes of alcohol dependence. Gradually he started beating his wife and small children. His wife reported of sexual abuse, marital rape, slashing of her private areas and extra marital relationships. Mr T was not ready to seek medical help and was forcibly admitted to a care home cum de-addiction centre by a local NGO.

g. Negative and Deteriorating Prognosis: The restricted environment of the centre, unresolved emotions pertaining to his HIV status, denigration by the community dwellers and inability to cope with the drastically negative life conditions made his physical and psychological realms to deteriorate significantly. He reported of the judgemental remarks and inappropriate treatment measures used by the centre. He also developed severe withdrawal symptoms including depression, hot flashes, spasms, insomnia and suicidal ideations which were over-looked in the process.

h. Further Interventions: The local NGO was forced to adopt Mr T and start with proper psychological and medical help for Mr T. It was less than a month of intensive care when he showed some initial signs of improvement. He changed his grooming styles, maintained proper hygiene, lessened his alcohol intake, and showed interest in learning computers. However, he committed suicide by hanging himself within a fortnight of the entire process. None of the survivors or his family could tap on the reason of his suicide when he was showing signs of improvement. His family was helped with bereavement counselling and appropriate rehabilitation before termination of further interventions.

Discussion

Alcohol Use Disorders not only bring about a negative change in the behaviour of a person, but has life-threatening impact on the neuro-chemistry of the person, physical health, resilience and coping, psychological health, social life, intrapersonal dimensions,

emotions, financial crunches and interpersonal challenges across all the tangents of life. Therefore, a need for appropriate de-addiction services becomes imperative. Proper psycho-education, experience and training need to be present both on the part of the professionals as well as the person seeking treatment. In addition a strong support, non-judgemental attitude and acceptance as well as maintaining the confidentiality of the person cannot be overruled at any cost. Utmost importance and insight regarding the disorder per say, as well as dealing with withdrawal symptoms, eclectic intervention procedures, motivation, positive thinking, dealing with relapse, adequate follow up, building support systems and easy accessibility to help-lines should also be included. De-addiction process is a huge step towards taking the person out of a strong psychopathological craving of abusing alcohol and similar substances. It implies a complete physical, psychological and social transformation of the person. Therefore, dealing with such a sensitive phase of a person needs to be done with intricate and careful measures so that it would not prove fatal and would lead to positive, meaningful life outcomes.

References

1. Littrell Jill (2014) Understanding and Treating Alcoholism Volume I: An Empirically Based Clinician's Handbook for the Treatment of Alcoholism: Volume Ii: Biological, Psychological, and Social Aspects of Alcohol Consumption and Abuse. Hoboken: Taylor and Francis. p. 55.
2. Hasin Deborah (2003) "Classification of Alcohol Use Disorders".
3. National institute on Alcohol Abuse and Alcoholism (2013) "Alcohol Use Disorder: A Comparison Between DSM–IV and DSM–5".
4. National institute on Alcohol Abuse and Alcoholism (2015) "Fetal Alcohol Exposure".
5. Association, American Psychiatric (2013). Diagnostic and statistical manual of mental disorders: DSM-5. (5th Edn) American Psychiatric Association, Washington, D.C, USA, pp. 490-497.