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A Qualitative Study of the Perception of Alcohol Dependence Syndrome Patients and Their Perspective towards Cognitive Therapy

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Abstract

Background: In the management of patients with alcohol dependence, the emphasis has been made on the appropriate use of treatment to prevent relapse. Patients' own perceptions of alcohol use and their experiences during treatment have not often been sought. Here, we aimed to see the patient's perception in relation to their alcohol use along with their perception towards received cognitive therapy sessions. Method: A total of 28 male patients from the outpatient department were screened. The data sources were handwritten notes taken by the therapist during individual therapy sessions and individual semi-structured interview conducted at the termination of therapy. The narrative data were analyzed for identification of the major theme using grounded theory analysis. Results: Patients attribute their drinking to factors external to them, they also had a number of misconceptions related to alcohol. The major theme of self-defectiveness and incompetency were common among the patients. Their attitude towards medication and counseling was not favorable. The social environment was perceived non-sympathetic. Cognitive therapy perceived as enhancing their knowledge of addiction but at the same time, found difficult for self-use.

Conclusion: Patients describe their attitude towards alcohol and other problem. Their perspective towards alcohol use and in self and social context helps us to understand that which kind of cognition compel someone towards drinking and why. This view is also central to informing the debate on the use of cognitive therapy in alcohol dependence and modifying the mode of delivery for these patients.

Keywords: Cognitive therapy; Patients' perception; Qualitative study, Alcohol Dependence

1. Introduction

The world health organization report states that 38.3% of the global population consumes alcohol and, on an average, an individual over 15 years of age consume 6.2 liters of alcohol annually. It is

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estimated that per capita consumption of alcohol in India increased from 1.6 liters from the period of 2003-2005 to 2.2 liters from the period of 2010-2012 (WHO, 2014). Kerala led the states in terms of alcohol consumption. The individual above the age of 15 years drank over 8 liters of alcohol per annum in the states of south India which was followed by Maharashtra and Punjab. According to the WHO report, around 30% of the total population of India were consuming alcohol in 2010. Approximate 93% of alcohol consumption was in the form of spirits, followed by beer (7%) and consumption of wine was among less than 1% of the population. Report of National Family Health Survey (IIPS, 2007) showed that nearly 35% of adult males consume alcohol. National Household Survey (Ray, 2004) reports current use of alcohol among 21% of males (12-60 years). Kumar et al. (2013) carried out a study in Punjab and his study result shows that Proportion of substance abuse was greater in the rural area(59.30%) and also among the 26-45 years old (63.91%). The most common addiction found to be for alcohol (33.78%) followed by alcohol with tobacco use (22.84%). Hence, Alcohol dependence has become a crisis with associated adverse social, physical, mental and economic consequences.

There are a number of psychological interventions approaches available to treat alcohol dependence and cognitive approach is one among them. Cognitive therapy (CT) attempts to reduce over emotional reactions and self-defeating behavior by modifying the dysfunctional thinking that underlies these reactions (Beck et al. 1991). Cognitive theory is well validated and effective in hundreds of randomized controlled trials across a wide range of psychiatric disorders and medical conditions (Beck, 2005). CT not only helps patients to overcome the specific disorders but also in prevents relapse (Hollon et al. 2005). In India intervention-based studies in substance use itself are scarce and therefore, patients' own perceptions of alcohol use and their experiences during treatment have not often been sought. Considering the fact that we have a smaller number of trained clinical psychologists and majority of these not working in other areas of addiction, the present study aimed to implement cognitive therapy for treatment of alcohol dependence. The primary focus was to see the patient's perception in relation to alcohol and associated problem along with their perception towards received cognitive therapy.

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2. Material & Method

A qualitative and explorative approach was used for gathering in-depth knowledge about patients' information. The two sources of qualitative data were used in the study:

1. The source of data was the handwritten individual psychotherapy session notes prepared by the therapist while conducting each therapy session with each patient. The narrative notes provided qualitative information about patient's difficulties related to alcohol use and their other underlying issues. The data helped in analyzing patient's thoughts and ideas regarding various issues of their life.

2. Another source of data was the narrative account prepared while individual interviews conducted at the termination of therapy. A semi-structured interview guide was developed based on previous research by Bowen et al. (2009) and a Performa was prepared after taking the final consensus from the expert committee to assess the feasibility of the implemented cognitive therapy sessions and other issues related to the process of intervention. Table-1 shows the individual interview guide used in the study.

Table:1- Interview Questions and Topics Individual Interview Guide

The following few statements would help us to understand your experiences regarding Cognitive Therapy program in which you participated. Please answer the questions honestly.

1. Which part of the therapy programme did you find the most & least enjoyable and why?

2. Which part of the therapy programme did you find the most &least useful and why?

3. Which part of the therapy programme do you think was most difficult & easiest to understand and implement/ how much you could follow/understand what was being said?

4. How much you find cognitive therapy programme suitable and satisfying?

5. To what extent cognitive therapy programme is practical to use in future?

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6. To what extent cognitive therapy programme is applicable in different circumstances?

7. To what extent cognitive therapy programme is successful or promising for self use?

8. How much you find the therapy program interesting?

9. To what extent you could implement the basics of the program out of clinical setup ?

10. Which part of the therapy programme do you think needs modification and why?

11. Any other comments:

2.1 Sampling procedure and study setting

Total twenty-eight Patients were screened from OPD based on following inclusion and exclusion criteria: All male participants in age range of 20 – 50 years, diagnosed with Alcohol Dependence Syndrome(ADS) according to ICD-10 (W.H.O. 1992), ready to give their informed consent to participate in the study, with basic reading and writing ability, any current major psychiatric disorder or medical condition as screened on MINI which can interfere with therapy process, any other substance dependence in past (except for nicotine and patient not amendable for intervention. Creswell (1998) also suggests an adequate sample size of 20–30 for qualitative study but this number can vary based on the purpose of the study and type of the data.

Figure: 1- Sampling of Patients for the Quality Study

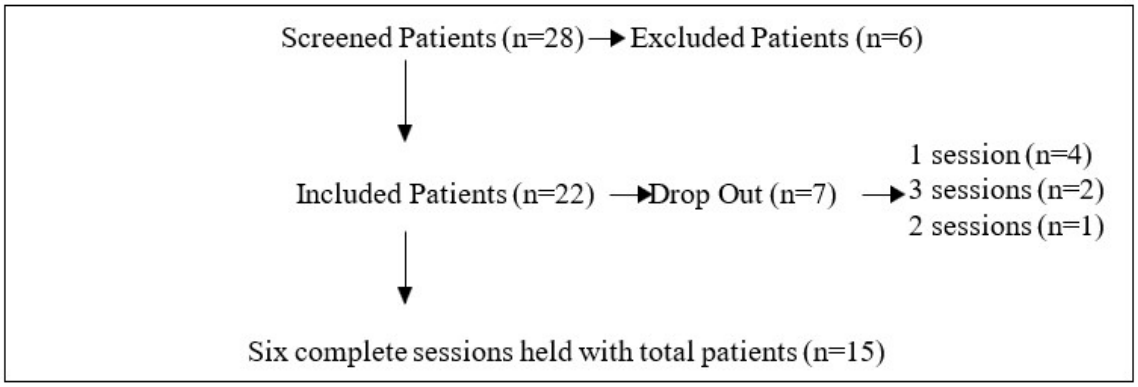

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Table: 2-Patient's Demographic and Clinical Characteristics

Mean Age (Range)	30 years (25-31)
Education	Up to 10^{th} std.(n=9), Above 10^{th} std.(n=6)
Marital Status	Married (n=9), Single (n=5), Separated(n=1)
Diagnosis	ADS with Comorbid NDS(n=12), Only ADS (n=3)
Form of Alcohol	Country made liquor(n=15)
Mean Age of onset(Range)	17 years(12-25)
Family h/o ADS	Positive (n=9), Negative(n=6)

*NDS: Nicotine Dependence Syndrome

2.2 Data analysis

Qualitative analysis using grounded theory methodology was used (Strauss and Corbin, 1990). This involves detailed coding of narrative material leading to the identification of core categories that can be employed as a conceptual framework for understanding the views and experiences of patients. In addition, the themes were identified as a result of an initial independent assessment by the three interviewers who subsequently reached a consensus agreement for these themes.

3. Results

The interview was effective in enabling most of the patients to talk openly about their perceptions of the intervention and related issues. The session notes helped to understand the patient's perspective about their problems either alcohol related or difficulties in other areas of life. Two of the patients not found very proactive to talk about their difficulties in session, although they were willing for sessions, basically to handle their alcohol related issues. Our findings seek to explicate

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the most central themes, or core categories, emerging from the analysis of the interview and therapy session material.

The qualitative analysis of narrative data from psychotherapy sessions emphasized on the following six categories:

1. Core problems
2. Alcohol related misconceptions
3. Attitude towards medication
4. Attitude towards counseling
5. Self-context
6. Social context

In this study using grounded theory analysis, the individual interview material could be assigned to three main categories:

1. Impactful part of cognitive therapy intervention
2. Unsatisfactory part of cognitive therapy intervention
3. Other issues related to process of intervention.

Core problems: The core problems of patients were identified through the session notes. Most patients attributed their drinking behavior to the factors external to them. The major areas of problems identified were in terms of relationships and occupation. They were clear that their real problem was not associated with drinking but, of coping with the difficult situation of their life.

A male patient who was stressed due to occupational difficulty reported:
'Whenever there was a downfall in my business, I couldn't tolerate it and started drinking. I don't think of taking drinks if my work goes well.'

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Other patients stated:

'I always wanted to marry a girl but my family didn't support me for that. I still can't love my wife; I don't feel affectionate to her and this is the major reason that I drink.'

'I was working hard on my client to convince him to buy the product of our company, and suddenly I came to know that the client was allotted to my colleague. I felt bad and started drinking.'

Patients were attributing their present problems to the incidents happened in past such as relationship breakup, problematic relationship with father since childhood, loss of business in past, betrayal by a friend etc.

Alcohol-related misconception: Most patients were clear about the fact that alcohol consumption is harmful to them. However, there were few who didn't think that their consumption was problematic. The majority believed that alcohol consumption helped in their survival with difficulties of life. A common theme noticed here was 'denial to handle the adverse situation' and to 'feel pleasure'. Their struggle generated drinking as a strategy to fight with problems. The patients were aware that their drinking was just an escape from the real problem. Some typical statements were:

'I know that alcohol doesn't solve my problem but help me to forget my pain.'

'Alcohol boost up my confidence to work efficiently at my office, otherwise, I feel worried about the work.'

'I work hard whole day and then just take a quarter in the evening to feel relaxed, I don't think it's bad.'

Attitude towards medication: All the patients had a strong opinion towards medication. Majority of them were not very positive towards the role of medication. They felt that medication was not helpful in solving the emotional problems and it just helps them to manage their physical craving and withdrawal symptoms. Few of the patients' narrative were: 'Medicine is helpful but for craving

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management only, It can't vanish my real problem. Even doctors don't have time to listen to me properly'

'I don't think I can stop drinking because I can't forget what had happened to me, what medicine can do about it.'

'Medicine helped me so much to stop my drinking but I am scared that I can again start if something wrong happens again.'

'Alcohol use completely depends on willpower and nothing else. I know I can again start.' Patients mentioned that alcohol can be stopped if real life problems are sorted out, and then they can stop alcohol even without medication. A common theme noticed that patients perceived 'lack of willpower' as a strong predictor of alcohol use. They were unaware of the role of the biological factors in substance use. Majority perceived drinking as a 'bad habit' rather than thinking in terms of disease.

Attitude towards counseling: Patients were completely unaware towards the role of the counseling in addiction. The majority never received any kind of therapy and therefore, were not enthusiastic to receive psychological intervention for their problem. A common understanding among the patients was that counseling is just an 'advice giving' which they have already received from someone at home or/and outside. Their typical statements were:

'I know about counseling, my brother has counseled me a lot that I should not drink but, I can't stop it. Even' everyone made me understand.'

'I have attended counselling classes during my admission; they taught us that it has many harmful consequences.'

Another common among most patients was that "I know everything". Their opinion was that since they are already aware of addiction, all pros and cons of taking alcohol, therefore they don't require counseling and it will not help much. Few patients received the counselling sessions from social workers and untrained professionals in non government organizations. It was also observed that

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majority were looking for an immediate solution from the therapist. The majority were not very proactive during sessions and a common theme observed that patients asked the therapist 'You tell me, what to do about it?'

Self Context: There were some common negative beliefs among these patients. They were critical of themselves that they are not as good as others. The themes of 'incompetency', 'defectiveness' were common among the patients. A doubt on self-efficiency found to be common. The typical statements were:

'I feel embarrassed in front of my family that I relapse again and again. People might think that I have no dignity.'

'I don't know why I am not like others, why do I get nervous publicly, I feel bad about myself.'

'I know that none loves me because I have always lost in my life, I am looser.' 'I work hard but still don't get success; God knows why I am unlucky.'

Social Context: Although most patients perceived their family members supportive, there was a strong sense that people were not sympathetic to their problem either it is drinking or anything else. Many believed that people don't want to know their real problem and family members keep an eye on them as if they are doing something wrong. A common theme of 'mistrust' was there. Many reported a feeling of shame and embarrassment when family members exposed them publicly for their drinking problem or reflect their doubt in front of outsiders. There was a pervasive theme of 'being misunderstood by others and a sense of mistrust by society.

These were few statements reported by patients:

'When I come back to home, my wife will always doubt and blame me that I am drunk. She never trusts me.'

'The people who are closed to me, they don't support me. If I go to talk about important topics, they just ignore me.'

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'I have lost social reputation; people take me lightly.'

Impactful part of cognitive therapy intervention: They experienced that they could now think about their drinking-related problem thoroughly. Otherwise, they had never given attention to understand the 'why' for their drinking. Another very consistent finding was that majority reported that they could now understand that their alcohol use is a 'disease' but, not a bad habit. Some of the typical responses were:

"Now I know its decease and why it is decease"

"I am not completely responsible for my problems"

"Chemical in brain has a strong role, that's why I am different from others in terms of drinking"

Sessions helped them to get rid of their self-blaming attitude. Most patients perceived the initial session very useful in term of developing insight regarding the role of biological factors. A consistent finding was that sessions helped them to think about their problem in depth and how it was regulated by their thought itself. A common theme of 'alternative perception' for situations found impactful as part of the intervention.

A typical statement was:

'I am changing my thinking to deal with my problems and it is really helping me to get rid of my negative state'

Unsatisfactory part of cognitive therapy intervention: Many patients believed that few concepts taught during intervention were not easy to keep in mind and verbalize in therapy sessions. The theme emerged was the use of 'difficult words' in therapy. Although the Hindi language was used mostly, patients found common difficulty with the use of English language terms (e.g., types of cognitive distortions; overgeneralization, catastrophization, selective abstraction etc). A common problem was noticed regarding 'maintaining the dysfunctional thought record diary'. Patients

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found it difficult to differentiate between situation, thoughts, and feelings, therefore, marinating diary at home was not so easy for them.

Other issues related to the process of intervention: Most patients had a common point that day of follow up for therapy sessions and medication should be the same. The distance found to be a major issue, therefore, majority requested for a gap of 2-3 weeks between two consecutive sessions. The majority reported from low socioeconomic status so their concern was financial and occupational restraints which questioned the feasibility of weekly intervention sessions. Another common observation was patients' dependency on the therapist, not making a proactive role in the treatment process and looking for immediate solutions.

4. Discussion

The patients identified with Alcohol Dependence syndrome for this study were derived using purposive sampling. The study reflects a broad perspective of the patients regarding the intervention they are receiving and also highlights their belief system.

The individual sessions, describe the core problems they are dealing with and how drinking is just a way to deal with their problems. The drinking not only exacerbates their problem but also creates a 'barrier' to seeking help for their real problems. Their drinking didn't solve

their problems but gave birth to several misconceptions about alcohol which can be called as positive outcome expectancy (Marlet and goddard, 1985)

Although they were taking medical treatment from the de-addiction center, their attitude towards medication was not positive. The role of biological factors was completely underestimated by them. A similar attitude was reported towards the role of counseling. They just compared it with advice giving and the majority believed in guru-chela relationship (Neki, 1973).

This is a fact that when a problem drinker enters into therapy, the major goal of therapist become to work on patent's substance use or to understand the alcohol related cognition. Here, the study

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reports that what they generally think in terms of themselves. The majority had a negative attitude towards self that they are defective or incompetent. (Shorey et al. 2013)

In terms of social context, the perception of the external environment including family members was skeptical. Many times, patients used mind reading i.e., they believed that others are thinking badly about them, intentionally ignoring them. However, there was no evidence in favor of their thoughts.

All patients reported common benefit as 'gaining insight of the alcohol use problem' and 'developing a new positive attitude towards their problem'. The negative part of intervention was the comprehension of difficult concepts of cognitive therapy, recalling these concepts and using further.

The qualitative findings of the study identified practical issues that could be examined in further research and which also show the contrast between the traditional cognitive therapy that is available and recommended which the patients would prefer.

The first, Psychiatrist doctors should focus on basic counseling of patients during their first visit to the hospital. They should also refer a number of patients for psychosocial evaluation rather than only giving medication to them. The second, considering the difficulties faced in implementation of cognitive therapy sessions, it is recommended here to use pictorial cards with the example to explain the nature of cognitive distortions. Third, to provide some notes to the patient to help them to understand the basic concepts of cognitive therapy so that they can go through these notes in case if they find difficulty in writing dysfunctional thought record diary. Fourth, it is also suggested simplifying the language while using cognitive therapy in a setting which is different from western culture. Hence, it is recommended to modify the cognitive sessions considering the patient population i.e. their educational background, proactivity, and attitude.

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