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RESEARCH ARTICLE

DEPRESSION AND ANXIETY AMONG PATIENT WITH ALCOHOL USE DISORDER AND THEIR COMPANION

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ABSTRACT

Background: According to the WHO-2020, a quarter of the world's population will suffer from a mental disorder due to substance abuse are projected to account for 15 % of the global disease burden. AUDs can be categorized as harmful use, hazardous use or dependence. Depressive and anxiety disorders as well as alcohol use disorders are among the most common psychiatric disorders in the general population that alarming as these disorders have a serious impact on a person's physical, social and occupational functioning and constitute a large economic burden to society. **Methods:** Cross-sectional study was conducted at tertiary care hospital in Department of Psychiatry. 90 Patients diagnosed with AUD andtheir 90companion who fulfilled inclusion criteria were included in study. Participants were subjected to social-demographic details, alcohol consumption details, AUDIT, HAM-D and HAM-A. **Results:** Of 90 AUD patients, 5(5.6%)-low, 14(15.6%)-medium, 42(46.7%)-high and 29(32.2%)-veryhigh AUDIT score. In AUD patients 27(30%) were depressed and 27(30%) were anxious & suggests that possible association with demographic variables(age, occupation and age of onset) and depression & with demographic variables(age, SEC and age of onset) and anxiety.In Companion, 21(23.3%) were depressed and 8(8.89%) were anxious & suggests that possible association with demographic variables(education, occupation,social economical status and duration of living with AUD patient) and depression with demographic variables(education, occupation, SEC and duration of living) and anxiety. **Conclusion:** This study indicated that AUD patients showed severe levels of depression and moderate levels of anxiety & companion had severe levels of depression and moderate levels of anxiety.

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INTRODUCTION

Mental health is a significant public health concern across the world. In 2010,mental and substance use disorders accounted for 7.4 % of all disability-adjusted life years (DALYs) worldwide, among which depression, anxiety, and alcohol abuse accounted for 40.5, 14.6, and 9.6 %, respectively (Whiteford *et al*., 2013). According to the World Health Organization, by 2020, a quarter of the world's population will suffer from a mental disorder, and mental diseases are projected to account for 15 % of the global disease burden (Organization, 2001). Mental disorders are associated with high economic costs (Greenberg, 1999; Rice, 1998), criminal activities (Qian, 2012), suicide rates (Goldney, 2002), and overall mortality rates (Walker, 2015). A recent meta-analysis estimated that 14.3 % of deaths worldwide, or approximately 8 million deaths each year, are attributable to mental disorders (Walker, 2015) Mental health is a significant public health concern across the world. AUD can be categorized as harmful use, hazardous use or dependence. Harmful alcohol use is characterized by an alcohol consumption pattern that is within the individual's control but which is causing physical or mental problems and may also have social consequences (Babor, 2001). Hazardous use of alcohol considers both the increased risk of harmful physical, mental or social consequences for the user and harm to others. Dependent alcohol drinking is characterized by alcohol use that takes over a person's life to the extent that they have a physiological or psychological need to continue drinking.

Dependence is the most severe is associated with many social, psychological and physical health problems (Mathers, 2004). Depressive and anxiety disorders as well as alcohol use disorders are among the most common psychiatric disorders in the general population. Heavy alcohol consumption has been implicated in the development of anxiety and depression (Brown, 1988). Many cross sectional studies have identified considerableco-morbidity between anxiety and depression, and alcohol abuse. This is alarming as these disorders have a serious impact on a person's physical, social and occupational functioning and constitute a large economic burden to society. This thesis focuses on the co-occurrence of depressive/anxiety disorders and alcohol use disorders, a phenomenon that occurs far more often than one would expect by chance. As persons with this co-morbid condition suffering from more severe impairment, more suicidal and poorer treatment outcomes than persons with either depressive/anxiety disorders or alcohol use disorders, prevention and treatment strategies may offer the opportunity to greatly improve public health. For this purpose, it is crucial to improve our understanding of the co-morbidity of these disorders. The World Health Organization (WHO) estimates that there are about 2 million people worldwide who consume alcoholic beverages and 76.3% with diagnosis of alcohol use disorder (2004). From a public health perspective, the global burden related to alcohol consumption, both in terms of morbidity and mortality, is considerable in most part of the world. Alcohol consumption has health and social consequences via intoxication (drunkenness), alcohol dependence and other biochemical effects of alcohol. In addition to the chronic diseases that may affect drinkers after many years of heavy use, alcohol contributes to traumatic outcomes that kill or disable at are relatively young age, resulting in the loss of many years of life due to death or disability. There is increasing evidence that besides volume of alcohol, the pattern of alcohol consumption can cause more than 60 types of disease and injury.

Some studies have provided information regarding the problems faced by the families of drug dependent people, faced with situations generated by the use, causing disagreement in the interpersonal relationships (Schenker, 2004). These situations are revealed by feelings more directly linked to the emotional context, such as ambiguity, impotency, anxiety, fear, guilt, deception, frustration, depression, and other problems related to the routine situations of everyday life. Among other losses, the distancing from friends and the reduction of social activities with a consequent impairment of the quality of life (QOL), is experienced by both the family and the drug dependent person. Alcoholic families were characterized by, poor communication among family members, lack of mutual warmth and affection, poor role functioning and compatibility between husband and wife. Also there is an absence of division of child care and the wife assuming the entire burden of care and receiving little from the alcoholic and almost total absence of any kind of joyful celebration whether in the personal, social or religious nature in the wealthy alcoholic families. Finally, the family environment will be, unpleasant, tense, cold and inhospitable.

AIMS & OBJECTIVE

- To determine the Prevalence of Depression and Anxietyamong patients with Alcohol use disorder
- To identifyassociation of Social-demographic variables with Depression andAnxietyamong patients with Alcohol use disorder
- To determine the Prevalence of Depression and Anxietyamong patient's companion
- To identify association of Social-demographic variables with Depression and Anxietyamong patient's companion

HYPOTHESIS

- There is significant Prevalence of Depression and Anxiety among patients with Alcohol use disorder.
- There is significant association between Social-demographic variables with Depression and Anxiety among patients with Alcohol use disorder.
- There is significant Prevalence of Depression and Anxiety among patient's companion.
- There is significant association between Social-demographic variables with Depression and Anxiety among patient's companion.

MATERIALS AND METHODOS

This is a Cross-sectional study. The study was conducted at tertiary care hospital in Department of Psychiatry. Patients diagnosed with alcohol use disorder and their companion who fulfilled inclusion criteria were included in present study. They were explained about study and written informed consent was taken.

Inclusion criteria:

Patient:

- Married male patient.
- Written informed consent signed by the patient.
- Patient with alcohol use disorder(according to DSM V) attending OPD or IPD

Companion

- Person not having alcohol use disorder.
- Written informed consent signed by the companion.

Exclusion criteria

- Patients refusing to give informed consent.
- Under the influence of recent alcohol or other substance use as judged clinically.
- Patients whose consciousness and/or orientation are impaired.
- Patients with active psychotic/manic symptoms.
- Patient uses other substance(except nicotine).

The data collection was performed after Participants were explained about the procedure, written consent was taken and then they were subjected to clinician rated survey forms which included social-demographic details, alcohol consumption details, AUDIT, HAM-D and HAM-A.

Alcohol-use disorder Identification Test (AUDIT) (Carey, 2003**)**: The AUDIT was developed by WHO as a simple method of screening an individual with three questions about hazardous alcohol use, three about dependence symptoms and

four about harmful alcohol use. It is scored as 0-4 with 5 answers on first 8 questions with higher values representing higher frequency. The last two questions, alcohol related injuries and others concerned about drinking, are responded as 0(no), 2(yes, but not in the last year), and 4 (yes, in the last year). This tool has enjoyed widespread use in clinical and research settings, including demonstrated psychometric properties in a similar population. Research has been conducted in a wide variety of countries and cultures suggesting its applicability as an international screening test. The average score of 8 and above has been identified as cut off level for both sexes as alcohol problems; 8-15 medium level of alcohol problems and ≥16 is high level alcohol problems and ≥20 possible alcohol dependence warranting specialized evaluation.

Hamilton Rating Scale for Depression(HAM-D) (Thompson, 2015): The Hamilton Rating Scale for Depression (HAM-D) has proven useful for many years as a way of determining a patient's level of depression before, during, and after treatment. It should be administered by a clinicians experienced in working with psychiatric patients. Although the HAM-D from lists 21 items, the scoring is based on the first 17. It generally takes 15-20 minutes to complete the interview and score the results. Eight items are scored on a 5 point scale, ranging from 0 = not present to 4 = severe. Nine are scored from 0-2 is good to excellent, validity is also good. Sum the scores from the first 17 items.

0 – 7 = Normal
8 – 13 = Mild Depression
14 – 18 = Moderate Depression
19 – 22 = Severe Depression
>= 23 = Very Severe Depression

Hamilton Rating Scale for Anxiety (HAM-A) (Gonzalez, 2013): The Hamilton Rating Scale for Anxiety (HAM-A) is widely used and well validated tool for measuring the severity of a patient's anxiety. It should be administered by an experienced clinicians. The HAM-A probes 14 parameters and takes 15-20 minutes to complete the interview and score the results. Each item is scored on a 5 point scale, ranging from 0 = not present to 4 = severe. The major value of HAM-A is to assess the patient's response to a course of treatment, rather than as a diagnostic or screening tool. By administering the scale serially, a clinician can document the results of drug treatment or psychotherapy. Sum the scores from all 14 parameters.

0 – 13 = Normal
14 – 17 = Mild Anxiety
18 – 24 = Moderate Anxiety
25 – 30 = Severe Anxiety

The data was analyzed by statistical methods using SPSS version 16. The study was conducted after obtaining prior approval from Ethics Committee of the Health Sciences Research Unit of institution. All ethical issues inherent in research involving human subjects were followed.

RESULTS

Study included total 180 participants were composed of 90 male AUD patients and their 90 companion who met the inclusion criteria. Most participants were living in rural area (73.3%), living in nuclear family(66.7%) and belonging to lower socioeconomic status(57.7%).

In AUD patients: The most prevalent age group was middle age group (36-45 years), accounting for 40%; The prevalent of other age group were 18-25 years had 3.3%, 26-35 years had 25.6%, 46-55 years had 22.2% and >55 years had 8.9%. As for their academic qualifications, 13.3% of patients were illiterate & 54.4.% of patients were only studied up-to primary. Most AUD patients (45.6%) were in the group of unskilled worker. Most of the AUD patients had started drinking alcohol at the age of 18-30 years(71.1%). most of the patient's total duration of intake of alcohol was 11-20 years (50%)

In Companion of AUD patients: The most prevalent age group was (26-35 years), accounting for 34.4%, The prevalent of other age group were 18-25 years had 13.3%, 36-45 years had 33.3%, 46-55 years had 15.6% and >55 years had 3.3%. Most of the companion's duration of living with AUD patients were 1-20 years (67.8%). As for their academic qualifications, 53.3% of patients were illiterate.

Table 1. Severity of Alcohol use disorder

No.	AUDIT score	Frequency
1	0-7 low level	5 (5.6%)
2	8-15 medium level	14 (15.6%)
3	16 19 High level	42 (46.7%)
4	>=20 very high	29 (32.2%)
Total		90 (100%)

90 patients were included in this study. Of 90 patients, 5 were low, 14 were medium, 42 were high and 29 were very high AUDIT score.

Prevalence of Depression and Anxiety in AUD patients: 90 AUD patients were included in this study, 27(30%) were depressed and 63(70%) were non-depressed. Among 27 depressed patients, 2(2.2%) had mild, 6(6.67%) had moderate, 12(13.33%) had severe and 7(7.8%) had very severe depression. 90 AUD patients were included in this study, 27(30%) patients were anxious and 63(70%) patients were non anxious. Among 27 anxious patients, 6(6.7%) had mild, 18(20%) had moderate and 3(3.33%) had severe anxiety. Non-parametric test (chi square test) was used to test the various hypothesis. Through the analysis completed, no statistically significant differences or association were found in the levels of depression and anxiety in AUD patients according to residence, education status, family type and duration of intake of alcohol. The differences in the levels of depression in AUD patients according to age, occupation status and age of alcohol intake onset & difference in the level of Anxiety in AUD patients according to age, socioeconomic status and age of alcohol intake onset. Out of 27 depressed patients, 2 patients was between 18-25yrs, 11 patients were between 26-35yrs, 11 patients were between 36-45yrs, 1 patient between 46-55yrs and 2 patients was >55yr. Association between different age group and depression was found significant (p value- 0.04). Out of 27 depressed patients, 1 patient was unemployed, 10 patients were unskilled worker, 9 patients were skilled worker and 7 patients were clerical/professional worker. Association between type of occupation and depression was found significant (p value- 0.033). Out of 27 depressed patients, 7 patient was from <18 years, 18 patients were from 11-30 years and 2 patients were from 31-45 years.

Association between age of onset and depression was found significant (p value-<0.001). Out of 27 anxious patients, 3 patients were between 18-25 yrs, 11 patients were between 26-35 yrs, 7 patients were between 36-45 yrs, 4 patients were between 46-55yrs and 2 pt was >55yr. Association between different age group and anxiety was found significant (p value-0.03). Out of 27 anxious patients, 2 patient was from upper class, 4 patients were from upper middle class, 5 patients were from lower middle class, 14 patients were from upper lower class and 2 patients were from lower class. Association between SEC and anxiety was found significant (p value-0.002). Out of 27 anxious patients, 6 patient was from <18 years, 19 patients were from 11-30 years and 2 patients were from 31-45 years. Association between age of onset and anxiety was found significant (p value- 0.029)

Prevalence of Depression and Anxiety in AUD patient's Companion: 90 AUD patient's companion were included in this study, 21(23.3%) were depressed and 69(76.7%) were non-depressed. Among 21 depressed, 1(1.1%) had moderate, 16(17.8%) had severe and 4(4.4%) had very severe depression. 90 AUD patient's companion were included in this study, 8(8.89%) were anxious and 82(91.11%) were non anxious. Among 8 anxious, 1(1.11%) had mild and 7(7.78%) had moderate anxiety. Out of 21 depressed patients, 4 patients were illiterate, 5 patients were studied up to primary school, 6 patients were studied up to secondary/higher sec. and 6 patients were studied up to graduation/post graduation. Association between level of education and depression was found significant (p value- <0.001). Out of 21 depressed patients, 7 patients were unemployed, 4 patients were unskilled worker, 5 patients were skilled worker and 5 patients were clerical/professional worker. Association between type of occupation and depression was found significant (p value-0.007). Out of 21 depressed patients, 2 patient was from upper class, 12 patients were from upper middle class, 2 patient was from lower middle class and 5 patients were from upper lower class. Association between SEC and depression was found significant (p value- <0.001). Out of 21 depressed patients, 8 patients were living from 11-20 yrs, 7 patients were living from 21-30 yrs and 6 patients were living more than 30 yrs with patients. Association between duration of living with patient and depression was found significant (p value- <0.001). Out of 8 anxious patients, 2 patients were studied up to primary school, 2 patient was studied up to secondary/higher sec. and 4 patients were studied up to graduation/post graduation. Association between level of education and anxiety was found significant (p value- <0.001). Out of 8 anxious patients, 2 patients were unemployed, 4 patients were skilled worker and 2 patient was clerical/professional worker. Association between type of occupation and anxiety was found significant (p value- <0.001). Out of 8 anxious patients, 6 patients were from upper middle class and 2 patients were from upper lower class. Association between SEC and anxiety was found significant (p value- <0.001). Out of 8 anxious patients, 5 patients were living from 11-20 yrs, 2 patient was living from 21-30 yrs and 1 patient was living more than 30 yrs with patients. Association between duration of living with patient and anxiety was found significant (p value- <0.001)

DISCUSSION

Present study included 90 patients who were suffering from alcohol use disorder and their companion.

The aim of the study was to find out the prevalence of depression and anxiety in patients of alcohol use disorder. And to find out prevalence of depression and anxiety among companion of patients of alcohol use disorder. In this study we also tried to correlate various social-demographic variables to depression and anxiety. Unlike other studies conducted in a general hospital setting or other alcoholism treatment centers, all the subjects were males in this study. The reason was that alcohol consumption by women is socially unacceptable in this region and women may not avail of treatment openly in a general hospital setting. Alcohol use disorders have been shown to have a particularly high rate of psychiatric co-morbidity, alcohol dependence is commonly reported to be co-prevalent with mood disorders and anxiety spectrum disorders. Of the 90 patients to whom AUDIT was administered, AUDIT scores estimated the level of drinking as low risk (0–7) in 5.6% of the total sample, hazardous (8–15) in 15.6%, harmful (16–19) in 46.7% and dependent (20 or above) in 32.2%. The maximum number of subjects (65.6%) started using alcohol at the age of 26-45 years. Most subjects(71.1%) had developed dependence on alcohol before the age of 30 years. The majority of subjects (50%) were taking alcohol for 11-20 years.

Prevalence of Depression among AUD patients: In present study found that 27% patients with alcohol use disorder were suffering from depression. One study found 39% prevalence of depression among patients of alcohol use disorder[17]. One similar study reported that depression was found to be the most common diagnosis among alcohol users[18]. They found 26% prevalence of depression among alcohol users which is similar to our study. Other studies found 28% prevalence of depression among patients of alcohol use disorder[19,20,21]. Association between depression and various social-demographic factors, we found significant association with education. In present study, other social-demographic factors like age, occupation and age of onset, we were found significant association with depression. This result is similar with another study (Prasad, 2013). Most of the patients were from rural background (73.3%), which could be explained by the fact that our hospital setting has more drainage of patients from rural population. While looking at the social-economical class of the patients, 57.7% of patients were from lower social-economical class. This can be explained on the basis that patients flow is likely to be more from lower social-economical class due to less expense spent over their management at this trust institution.

Prevalence of Anxiety among AUD patients: In present study found that 27% patients with alcohol use disorder were suffering from anxiety. The ECA study found that 19.4% of those with alcohol users had a co-morbid anxiety disorder and NESARC study result showed a prevalence rate of 17.5%. One similar study reported 45.8% prevalence of anxiety among patients with alcohol dependence (Kumar, 2010). Association between anxiety and social-demographic factors(age, SEC, age of alcohol intake onset) was found significant. Our finding was somewhat similar with study which found no significant association between anxiety and social-demographic factors like age, residence, family type, education and SEC.

Prevalence of depression in companion of AUD patients: In present study, we found prevalence of depression among companion of AUD patients is 23.3%. This result is similar to another study which found 26% prevalence among spouses (Kishor, 2013).

Table 2. Association between Social-demographic variables with depression and anxiety of AUD patient

Social-demographicvariables		Depressed	Non depressed	Chi square	P-Value	Anxious	Non anxious	Chi square	P-Value
Age	18-25	2	1	6.733	0.04*	3	0	29.989	0.03*
	26-35	11	12			11	12		
	136-45	11	25			7	29		
	46-55	1	19			4	18		
	>55	2	6			2	6		
Residence	Rural	21	45	1.546	0.818	23	43	4.002	0.261
	Urban	6	18			4	20		
Education	Illiterate	0	12	11.911	0.453	2	10	6.388	0.701
	Primary	15	34			14	35		
	Secondary/ higher-sec	6	11			5	12		
	Graduate/ post-graduate	6	6			6	6		
Family Type	Joint	7	23	5.161	0.271	6	24	5.143	0.162
	Nuclear	20	40			21	39		
Occupation	Unemployed	1	1	22.455	0.033*	1	1	11.672	0.232
	Unskilled	10	31			13	28		
	Skilled	9	9			7	11		
	Clerical/ professional	7	22			6	23		
SEC (socioeconomic class)	Upper	2	2	24.806	0.073	2	2	31.015	0.002*
	Upper middle	4	11			4	11		
	Lower middle	6	13			5	14		
	Upper lower	14	25			14	25		
	Lower	1	12			2	11		
Age of onset	<18	7	1	46.335	<0.001*	6	2	14.063	0.029*
	18-30	18	46			19	45		
	31-45	2	16			2	16		
	>45	0	0			0	0		
Duration of intake	1-10	9	24	5.807	0.669	8	25	4.744	0.577
	11-20	15	30			16	29		
	21-30	3	9			3	9		
	>31	0	0			0	0		

*Statistically significant difference

Table 3. Association between Social-demographic variables and Depression and Anxiety of AUD patient's companion

Social-demographic variables		Depressed	Non depressed	Chi square	P-Value	Anxious	Non Anxious	Chi square	P-Value
Age	18-25	0	12	18.118	0.112	0	12	4.462	0.813
	26-35	6	25			4	27		
	36-45	7	23			3	27		
	46-55	6	8			1	13		
	>55	2	1			0	3		
Duration of living with patient	1-10	0	23	22.582	0.007	0	23	54.093	<0.001
	11-20	8	30			5	33		
	21-30	7	8			2	13		
	>30	6	8			1	13		
Education	Illiterate	4	44	75.316	<0.001	0	48	29.303	<0.001
	Primary	5	22			2	25		
	Secondary/ higher-sec	6	0			2	4		
	Graduate/ post-graduate	6	3			4	5		
Family Type	Joint	8	22	4.846	0.183	1	29	1.795	0.408
	Nuclear	13	47			7	53		
Occupation	Unemployed	7	26	54.093	<0.001	2	31	46.102	<0.001
	Unskilled	4	40			0	44		
	Skilled	5	0			4	1		
	Clerical/ professional	5	3			2	6		
SEC (socioeconomic class)	Upper	2	2	46.335	<0.001	0	4	27.461	<0.001
	Upper middle	12	3			6	9		
	Lower middle	2	17			0	19		
	Upper lower	5	34			2	37		
	Lower	0	13			0	13		
Residence	rural	15	51	4.388	0.222	6	60	0.378	0.828
	urban	6	18			2	22		

*Statistically significant difference

One study found 33% prevalence of depression (Ariyasinghe, 2015). Similarly, other study reports a prevalence of depression of 25% among wives of alcoholic partners. Our study found significant association between depression & education, occupation, Social economic status and duration of living with AUD patients. In present study, we found that all companion with depression were living with patients more than 10 years. For this variable, no similar studies were found. Also in present study there were other variables like education, occupation and SEC are highly significant with depression. Other social-demographic variables age and family type are not found significant with depression.

Prevalence of anxiety in companion of AUD patients: In present study, we found prevalence of anxiety among companion of AUD patients is 8.89%. The prevalence of anxiety was assessed by using Hamilton anxiety rating scale. One study found 15% prevalence of anxiety among spouses. Another study reported approximately 6-13% of spouses have anxiety. Our study found significant association between anxiety & education, occupation, Social economic status and duration of living with AUD patients. Present study also found significant association between anxiety and other variables occupation and SEC. Other social-demographic variables age, family type and duration of living with patients of alcohol use disorder were not found significant anxiety.

CONCLUSION

The consumption of Alcohol implies a great emotional burden on AUD patients & their companion and negative impact on people's physical, mental and psychological well-being, quality of life and productivity. This suggests that, it is essential for the psychological preparation to begin with the psychiatrist or psychologist. This study aimed at identifying in AUD patients knowing the possible associations and differences with various social-demographic variables(age, occupation and age of onset) and the levels of depression & with various social demographic variables(age, social economical status and age of onset) and the levels of anxiety. Also this study suggested that their companion knowing the possible associations and differences with various social demographic variables(education, occupation, social economical status and duration of living with AUD patient) and the levels of depression & with various social demographic variables (education, occupation, social economical status and duration of living with AUD patient) and the levels of anxiety Results indicated that, in the AUD patients showed severe levels of depression and moderate levels of anxiety. In this study AUD patient's companion suggested severe levels of depression and moderate levels of anxiety. The present study was done in a tertiary care hospital, hence the result cannot be generalized to the population at large. The study has been primarily cross sectional in nature. The sample population was small in number. A larger sample size is needed to comment more accurately on the prevalence. There is no control group in our study. So we can't compare psychiatric morbidity and quality of life in spouses of alcohol dependent patients with normal population. The results of this study provided an opportunity to reflect on our practices and behaviour as health care professionals. They should be considered as a contribution to understanding the complex phenomenon that concerns the identification of emotional symptoms associated with the AUD patients and their companion by health care professionals, thus preventing their progression to pathological situations. Some suggestions arose from these results, such as: promoting alcohol De-addiction training programme and Pharmacotherapy for the AUD patients; establishing a consultation together with the remaining multi-professional team which included an interview with a structured script, where emotional states of depression and anxiety could be conceptualized through attitudes, behaviour, moral support, motivation enhancement and words aiming at an autonomous and interdependent intervention to target the problem; and intervening interdependently like, Rationally motivational enhancement therapy(RMET), Interpersonal psychotherapy, Family therapy, Supportive psychotherapy.

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