

## RELAPSE PRECIPITANTS IN OPIATE ADDICTION : ASSESSMENT IN COMMUNITY TREATMENT SETTING

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### ABSTRACT

*Drug and alcohol dependence is a chronic relapsing disorder so that there is a need for continued care to prevent relapses. Relapse is generally understood as a return to earlier pattern of use for a drug after a period abstinence. The factors leading to relapse can be intra-psychic and interpersonal. In an attempt to understand the factors leading to first use and relapse in opioid dependence this study was conducted in a community treatment setting at the De-addiction centre of All India Institute of Medical Sciences. The sample consisted of 25 consecutive subjects with opioid dependence who had used the opioid after a period of 3 weeks of self reported abstinence in the 6 months prior to assessment. A semi-structured interview schedule was used to interview the subjects. The results showed that about 2/3rds of the sample had heroin dependence whereas the rest had buprenorphine dependence. After the first use, which occurred after a mean abstinence of 16.4 weeks, 19/25 subjects progressed to regular use (relapse) within a mean period of 8.7 days. The reasons for first use and regular use were almost the same and the common reasons were sleep disturbances, body ache and urges to take the drug. Some subjects reported sadness, family conflict and peer influences also as reasons for first as well as regular use. This preliminary study found that the factors leading to first use and regular use in our subjects are the same and that very soon after the first use the regular use ensues thus interventions that focus on preventing first use need to be emphasised.*

*Key words : Lapse, relapse, opioid dependence, community*

Drug and alcohol dependence disorder is characterised by a chronic course with frequent relapses. The implications of chronic relapsing course are reflected in the need for continued treatment and measures to handle relapses. Relapse has been variously understood, however, most agree that it amounts to a return to earlier (dependent) pattern of use. In contrast, drug reuse is implied as 'lapse' i.e. a pattern ranging from single use to earlier use not amounting to dependent use. Within the context of richly variable behaviour, relapse may be interpreted either as a presence or absence of a behaviour (dichotomous) or a range lying above a certain threshold (a continuum threshold

interpretation). Most often relapse implies a change to undesirable status associated with drug use (Marlatt, 1979).

According to Marlatt (1979), factors contributing to relapse are categorised as intra psychic and interpersonal. Various authors have cited negative emotional states, social isolation and family factors as predictors of relapse (Heather et al., 1991). Donovan (1996) reported that negative emotional states like anger, sadness are particularly important. These emotions followed by interpersonal conflict and social pressure to consume drugs often led to relapse (Sandahl, 1984). On the contrary, Litman et al. (1983), emphasized that positive emotional

states could also cause relapse.

The Drug Dependence Treatment Centre (DDTC), All India Institute of Medical Science (AIIMS) carries out community based treatment service and high relapse rates have been noted in this population. In one of earlier study, we found that among 89 heroin users, only about 17% were abstinent at the end of one year. However, 71% had abstained at some time in this period (DDTC, 1996). The present study is not an outcome study and only attempts to assess the reasons for relapse in a community sample of opiate dependent subjects.

## MATERIAL AND METHOD

**Setting :** The study was conducted in our community treatment centre situated in West Delhi. The clinic serves a population of about two hundred thousand, most belong to middle and lower middle socio-economic status from urban slum and urban village. The population is largely migrant and many are employed in various small scale industries nearby. The clinic functions five days (Monday to Friday) in a week located in the middle of a residential-cum-market area. Patients with alcohol and drug dependence are treated with pharmacotherapy and psychosocial interventions (single, extended group counselling and family session). Patients and their families are also encouraged to visit the centre for consultation on any drug related issue concerning self or the family. About 3000 patients (old and new) are seen in the clinic in a year and a large majority of them are opiate user. Most patients with opiate dependence receive oral buprenorphine (1.2-1.8 mg per day) for six months to two years in addition to the above mentioned psychosocial therapies. These activities are carried out by two trained nurses and a medical social worker. Medical doctors (consultant and resident) are available twice a week. As was said earlier that in spite of treatment and regular follow-up, many patients relapsed after variable length of abstinence.

**Sample :** Twenty five consecutive subjects

attending the clinic fulfilling the following criteria were included in the study: i) ICD-10 criteria for opiate dependence; ii) reuse/relapse to opiate use following a period of abstinence from opiates for at least 3 weeks in the previous one year; iii) had reported for follow up at the centre in the above one year; and iv) gave verbal consent for participation.

If a person had more than one episode of abstinence (3 weeks or longer) in the above period, the most recent period of abstinence was considered as the index episode. Finally, if a person was abstinent at the time of interview but had fulfilled the criteria in the above one year period, he was included in the study.

In this study a theoretical dissociation between first use (reuse) and relapse was made based on the Marlatt's (1979) lapse and relapse. Reuse was defined as any opiate use in this one year period, and use of opiates for four times or more in a week was defined as relapse.

**Procedure :** The subjects were interviewed by the Medical Social Officer (BP) using a semi-structured interview schedule prepared for the purpose of study. The interview focussed on the circumstances around the use of opiate by the patient for the first time after having abstained completely for at least 3 weeks. If the drug use persisted beyond the first use, inquiry was made into the circumstances leading to relapse (as defined).

Details of various abstinence attempts in the past (life time) as well as in the last year and the details of treatment in the above period were recorded. Subjects' self-report was the major source of information. Collateral sources were used for verification wherever available. Not much inconsistency was noticed between the reports given by the subjects themselves and their relatives.

**Tools :** Semi Structured Interview Schedule. Relapse inventory developed by the authors for the purpose of study collected information on: i) demographic details; ii) drugs used (opiate or any other drugs); iii) details regarding previous efforts of abstinence; iv) reasons for first use

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(lapse-any use) and v) reasons for continued use (relapsed-as defined).

It took about 30 minutes for the schedule to be administered.

### RESULTS

The average age of these subjects was 34.1±8.5 years (range 20-56 years). All were males, about 2/3rd were married and 16% were single. Two thirds of the sample had been using heroin as a primary drug and the rest i.v. buprenorphine. The average duration of dependence was 11.9±5.8 years range (3-27 years). In the previous one year, the subjects had made on an average 46.1±22.5 visits (range 13-84 visits) to the clinic.

The clinical details and progress from first use to relapse is given in table 1. Following this

TABLE 1  
DETAILS OF ABSTINENCE AND  
PROGRESS OF DRUGS USE

	Mean & S.D.	Range
No. of abstinence attempts (excluding index)	1.66±0.96	(0-3)
Longest period of abstinence (excluding index in weeks)	16.4±27.5	(04-130)
Index Abstinence- (duration in weeks)	19.0±21.6	(04-78)
Time taken in days for Doubling dose	8.7±15.7	(3-45)
Withdrawals	12.4±11.1	(1-45)
Relapse	9.5±10.1	(2-60)

first use (lapse), 5 subjects (20%) used infrequently and most i.e. 19 (76%) relapsed in the remaining one year. Only one subject used it once. The duration of index period of abstinence for which assessment was done was 16.4±27.5 weeks (range 4-130 weeks). During this period of abstinence 17 subjects (out of 25) had used several other compounds. These include alcohol by 65%, cannabis by 65% and 23% used benzodiazepines. In the past these patients had attempted to abstain (1.7±0.9 times), with an average duration being 19.0±21.6 weeks. Drug use occurred mostly in the company of friends

(60%) and at home in nearly half the cases.

Table 2 gives the reasons for first use and relapse, which were similar. Common reasons

TABLE 2  
REASONS FOR FIRST USE AND REGULAR USE

Reasons	First Use (N=25)		Relapse (N=19)	
	N	%	N	%
Persistent sleep disturbance	13	(52)	6	(36.6)
Persistent body ache	12	(48)	12	(63.2)
Sadness	10	(40)	-	
Being in company of user	10	(40)	6	(36.6)
Urges/Craving	10	(40)	3	(15.9)
Family conflict	8	(32)	3	(15.9)
Fun	-		3	(15.9)

cited were physiological namely sleep disturbance, body ache and urges. Psychological reasons like sadness, social influences and being in company of user were cited in about 40% of the cases. Surprisingly, urges, sad mood and family conflict were more important for first use though not for continued use.

The time lag between first use and relapse varied between 2 to 60 days with an average of 8.7 days, and the time taken to double dose and to develop withdrawal symptoms on an average was 12.4 and 9.5 days respectively. This indicates a rapid progress from lapse to relapse amongst those (majority) where it occurred.

### DISCUSSION

Drug use after a period of abstinence is a common phenomenon in drug abuse management and often single use progresses to continued use. It is important to document these reasons for early identification and initiate intervention. Drop-in-centres like ours offer an opportunity to explore and intervene quickly.

The interview schedule used in this study assessment made a differentiation between 'lapse' and 'relapse'. A minimum of three weeks abstinence was chosen because opiate withdrawal syndrome may last up to 3 weeks, and drug use within this period should be understood as continuation of this disorder

without remission. Information was obtained for a period of 1 years prior to inclusion as it was felt that recall for periods beyond 1 year would be difficult and unreliable. Previous research on coping mechanisms carried by us used retrospective recall for one year time frame successfully (Hemraj & Chavan,1996). It was observed that the subjects understood the questions easily and were able to recollect without undue difficulty. They were able to distinguish between the first use (lapse) and the patterns of continued use as defined in this study quite comfortably and gave differential responses.

The results indicate that the patients had made a number of visits in this one year and they relapsed even though they had received psychosocial therapies and were maintained on oral buprenorphine. The reasons for first use and regular use (relapse) were alike. Physiological and psycho-biological disturbances viz., persistent body ache, sleep disturbance, sad mood and craving were the major reasons. These have been highlighted earlier by proponents of psycho-biological theories (Gorski & Miller,1979; Adinoff et al.,1995). However, the data are on alcohol users and information among opiate users is scarce. These symptoms were present in our patients inspite of agonist medication. It is also seen that a period of 3 weeks of abstinence may not be adequate for biological disturbances to recover completely even when treatment includes use of substitute opiates. May be additional medications for insomnia, depression and higher dose for control of craving are required to prevent relapse. The subjects also reported interpersonal factors (family conflict, company of user) for the first use as well as for continued use. These are in keeping with the result reported from other studies among alcohol as well as opiate users (Annis,1990). In a recent Indian study, it was seen that among heroin dependent subjects, negative mood states and social pressure were the common reasons for relapse (Kumar & Singh, 1996).

The development of regular use and dependent use after first use was rapid, and most (76%) progress to regular use. Connors et al. (1996) reported that cumulative relapse rate for alcoholism following treatment was 35% at two weeks and 58% at 3 months. Ninety percent had at least one drink. Such data, however, is not available for opiate dependence. Thus intervention should focus on preventing first use. It is unlikely that infrequent use of opiate would continue. Further, even when the patients abstained from opiates, many used other intoxicants. Thus treatment should also focus on use of these substances. Finally, it should be remembered that mere exposure to high-risk situation by itself does not lead to relapse, coping behaviours are also important.

In conclusion, it seems that the reasons for first use and relapse in our subjects are predominantly psycho-biological, assessment for the reasons is feasible in the community setting and our treatment package needs to be re-examined.

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