RESEARCH PAPER | Medical Science | Volume : 4 | Issue : 4 | Apr 2014 | ISSN - 2249-555X

Alcohol Dependence and Coping Mechanisms : a brief review

KEYWORDS: coping, coping mechanisms, alcohol dependence

Anup Bharati
Assistant Professor, Department of Psychiatry, Lokmanya Tilak Municipal Medical College, Mumbai

*** Avinash De Sousa**
Research Associate, Department of Psychiatry, Lokmanya Tilak Municipal Medical College, Mumbai
* Corresponding Author

ABSTRACT *Coping mechanisms and coping styles in an under studied area in alcohol dependence. The following articles comments about the coping mechanisms used in alcohol dependence and their relationship to outcome studies in alcohol dependence. There is a dire need for further studies in this area using various interventional strategies that shall help elucidate the link between coping mechanisms and recovery in alcohol dependence*

INTRODUCTION

Patterns of drinking in alcohol dependents differ from "healthy" drinkers in their ability to cope with the demands of everyday life and in their beliefs about alcohol. According to this perspective, deficiencies in more adaptive coping skills and positive expectancies about alcohol's effects operate independently and jointly to promote the use of drinking as a coping mechanism. Reliance on alcohol to cope should lead to heavier drinking and over time, increase the risk of alcohol abuse. This perspective on the development and maintenance of alcohol abuse has heavily influenced the content, techniques, and goals of a range of alcohol treatment programs. In particular, the teaching of general and alcohol-specific coping skills, and to a lesser extent the modification of beliefs about the effects of alcohol, are integral components of various treatment approaches (e.g., social skills training).

ALCOHOL DEPENDENCE AND COPING

Coping may be defined as the cognitive and behavioural efforts to manage specific external and /or internal demands appraised as taxing or exceeding the resources of the individual.[1]

It is a common practise in psychiatric studies to focus exclusively on psychopathology and singularly ignore the intrinsic positive qualities of the population being studied. Such an approach, by focusing on the morbid, excludes that which is positive in the individual. It is therefore important to understand the inherent coping mechanisms in any population, for effectively planning any intervention strategies.

Two general coping strategies have been distinguished.[1]

a) Problem solving strategies-efforts to do something active to alleviate stressful circumstance.
b) Emotion focused coping-efforts to regulate the emotional consequences of stressful or potentially stressful events.

The predominance of one over the other is determined by

i) Personal style – some people cope more actively than others
ii) Type of stressful event - when stressors are controllable, such as at work, active coping strategies are used and when stressors are beyond individual control, as in illness, passive coping strategies are used.

An additional distinction that is often made in coping literature is between active and avoidant coping strategies. Active coping strategies are either behavioural or psychological responses designed to change the nature of the stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into activities or mental states that keep them from directly addressing stressful events. Generally speaking, active coping strategies, whether behavioural or emotional, are thought to be better ways to deal with the stressful events and avoidant coping strategies appear to be a psychological risk factor for adverse responses to stressful life events.[2]

Active coping strategies appear reliably to produce better emotional adjustment to chronically stressful events than do avoidant coping strategies. Thus psychological distress is reduced if active coping strategies are used.

Problem focused coping is correlated to positive mood. In contrast self blame, escape avoidance, distancing, fatalistic attitude are associated with poorer outcomes such as higher levels of depressed mood and more severe reaction to bereavement.

In the conceptualization of coping, one must remember three important ingredients [3]

a. Coping need to be a completed 'successful' act, but an attempt has to be made.
b. This effort need not be expressed in actual behaviour; but can be directed to cognitions as well.
c. A cognitive appraisal of the taxing situation is a prerequisite of initiating coping attempts.

The assessment of coping can be a description of the cognitions and behaviours of a person dealing with a stressful situation. This approach does justice to the fact that coping is a process. Thus coping does not represent a homogenous concept. Instead, it is a diffuse umbrella term. Hence, although there are scores of 'instruments' available to measure coping, many issues remain unresolved.

SOCIAL COGNITIVE MODELS AND COPING IN ALCOHOL DEPENDENCE

Due to lack of methodological sophistication in the measurement of coping, literature on this aspect is extremely sparse and confusing. Nonetheless, the study of coping is important, because, for too long a time psychiatrists have drawn their conclusions about behaviour from 'patients' or deviants. Research on reactions to stress situations attempts to redress this imbalance by paying attention to persons who handle life's contingencies well.

Coping is also important in Alcohol dependent patients both in terms of development of Alcohol dependence and sustained abstinence and tendency to relapse. It may indirectly affect the course of Alcohol dependence due to its vital role in co-morbid psychopathologies like Depression and Anxiety.

Volume : 4 | Issue : 4 | Apr 2014 | ISSN - 2249-555X

By expanding the social cognitive model, it is possible to speculate on the mechanisms involved in the aetiology and maintenance of dependent drinking. Figure 1 presents a schematic outline of how outcome expectancies, self-efficacy, and coping may work together to maintain drinking behaviour.

The key features of Figure 1 are the primary role coping plays in the prediction of dependent drinking, and the key role of drinking refusal self-efficacy in predicting community drinking.

The first phase describes the adoption of avoidant coping behaviours. Based on social cognitive theory, it is suggested that environmental factors are mediated by cognitions in determining coping behaviour. These environmental factors could consist of a number of aspects such as family history or an environmental stressor such as a relationship problem.

In an individual dependent on alcohol, the cognitions mediating these environmental effects may be negative cognitions regarding the ability to effectively solve the problem causing stress, a low self-esteem, low motivation, or any number of cognitions related to coping. These negative cognitions may lead the individual to adopt avoidant coping behaviours, rather than attempting to actively resolve the source of stress.

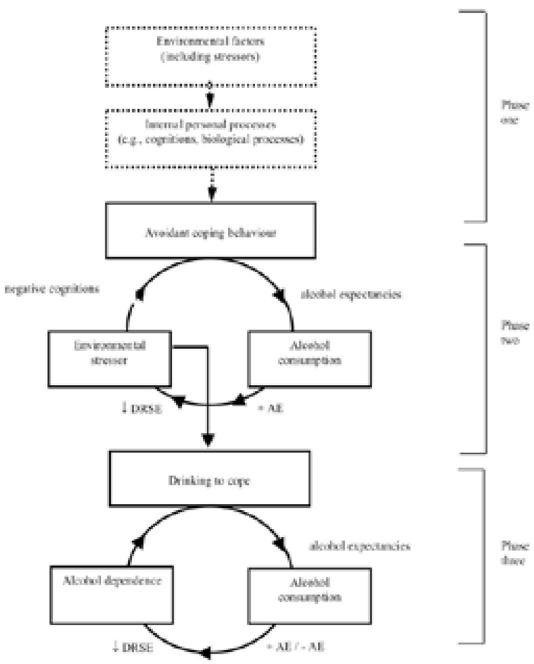

Figure (1): Dependent drinking is acquired and maintained through a continuous cycle of cognitive and behavioural factors.

While this pathway has not been examined in expectancy research to date (and is thus represented by a dotted line), based on Bandura's notion that cognitions mediate environmental factors to influence behaviour, and the bulk of research supporting this proposition, it seems a viable pathway for the development of coping behaviours. [4,5,6] Naturally, future research investigating this pathway would be beneficial to the understanding of how coping behaviours are developed.

The second phase describes how coping, alcohol expectancies, drinking refusal self-efficacy and drinking behaviour are related, and outlines a continuous learning cycle, which reinforces the use of alcohol. Use of avoidant coping behaviours to minimise a stressful situation results in two outcomes, which is not depicted in figure 1. First successful avoidance of the problem reinforces the use of avoidant coping strategies. Second, a failure to address the source of stress may ultimately exacerbate the problem, leading to an increase in stress and other negative outcomes, such as a depressed mood.

In the third phase of the model depicted in figure 1, the continuous reinforcement of drinking behaviour established in step two leads to alcohol dependence. With the reinforcement of positive alcohol expectancies, and a diminished drinking refusal self-efficacy, an individual may begin to adopt drinking to cope as their primary coping strategy. A belief that alcohol will help an individual cope with a situation leads to an increased alcohol consumption, and a continued decline in refusal self-efficacy.

It is widely believed that people drink in response to stress. This notion was formally proposed by Conger 1956 as the tension reduction hypothesis of alcohol consumption.[7] in its simplest form; tension reduction theory proposes that alcohol reduces tension and that people drink in order to experience relief from tension. Numerous surveys have shown that both social and problem drinkers expect alcohol to relieve tension, anxiety and other stress- endangered negative emotions and to promote relaxation.[8,9,10] Moreover, Correlational studies of motives for drinking have consistently shown that from 10 % to 25 % of drinkers report drinking to cope with or regulate negative emotion.[11,12] Collectively these data provide indirect support for a tension reduction model of alcohol use; many if not most individuals believe that alcohol reduces negative emotions, and a substantial minority of drinkers indicate that they use alcohol strategically to cope with negative emotions.

Clinically many patients report that they drink to cope with stressful situations. Drinking to cope is defined as the tendency to use alcohol to escape, avoid, or otherwise regulate unpleasant emotions. Both theory and research suggest that individuals who lack effective alternative coping responses are more likely to drink in response to stressful situations or circumstances. According to social learning models of alcohol use and abuse [13], alcohol use serves as a general coping mechanism invoked when other presumably more effective coping responses are unavailable.

MAJOR STYLES OF COPING IN ALCOHOL DEPENDENCE

Correlational studies of two major styles of coping behaviour-- active, problem-focused coping and avoidant, emotion-focused coping have shown them to be differentially related to stress- induced alcohol use in adult samples.[14] In two studies among recovering alcoholics and spouses of alcoholics patients, individuals who relied on avoidant coping strategies that served to discharge or deny emotion were more likely to drink in response to stressful events.[15,16] However, more active, problem-focused coping did not predict alcohol use in response to stress in either study. In contrast, in a community-based sample of older adults neither active nor avoidant coping strategies used in response to a recently experienced stressful event predicted substance use.[17,18]

In males, having strong positive alcohol expectancies and relying on avoidant forms of emotion coping were independently predictive of all alcohol related outcomes.[19]

Marlatt and colleagues suggested that alcohol was used in an attempt to cope with the negative emotions aroused by the provocateur when no coping alternative was provided.[20] That subjects may drink in response to experimental manipulations designed to engender negative affect or emotion (e.g., anxiety or decreased self-esteem) has been replicated in other studies as well.[21,22]

Numerous studies have shown that reliance on alcohol as a coping mechanism is associated with heavy or abusive drinking.[11,12] For example, 93% of a sample of diagnosed alco-

Volume : 4 | Issue : 4 | Apr 2014 | ISSN - 2249-555X

holics were classified as escape drinkers, in contrast to the typically low rates of endorsement of drinking-to-cope items among non-problem drinkers.[12] Perhaps the most convincing evidence regarding the relevance of general coping skills to patterns of abusive drinking derives from research with alcoholic populations. Relapsed alcoholics were discriminated from recovered alcoholics and matched community controls at 6-month and 2-year follow-ups by their use of avoidance coping strategies in response to a recently experienced stressful event.[23] Treatment outcome studies of various skill-oriented programs provide additional indirect evidence that acquisition of appropriate coping responses may lead to a reduction in abusive drinking.[24]

CONCLUSIONS

Research on coping mechanisms in alcohol dependence is inconclusive with multiple theories and methods of coping being posited. There is a need to examine various treatment measures along with different styles of coping and see which benefits this group of patients to the maximum.

REFERENCE

1. Folkman S, Lazarus RS. Manual for ways of Coping Questionnaire. California: Consulting Psy Press, 1998:1-33. | 2. Holahan CJ, Moos RM. Risk, resistance and psychological distress. A Longitudinal analysis with adults and children. J Abnorm Psychol 1987;96:3-13. | 3. Schwarzer R, Schwarzer C. A critical survey of coping instruments. In: Zeidnen M, Endler NS eds. Handbook of coping. New York: Wiley and Associates,1996. | 4. Bandura A. Social learning theory. NJ, Prentice Hall. 1977 | 5. Bandura A. Social foundations of thought and action: A social cognitive theory. NJ, Prentice Hall. 1986. | 6. Bandura A. Self-efficacy: The exercise of control. New York: W.H. Freeman & Co. 1997. | 7. Conger JJ. Alcoholism: Theory, problem and challenge. II. Reinforcement theory and the dynamics of alcoholism. Q J Stud Alc 1956;13:296-05. | 8. Goldman MS, Brown SA, Christiansen BA. Expectancy theory: Thinking about drinking. In: Blanc HT, Leonard KE, eds. Psychological theories of drinking and alcoholism. New York: Guilford Press, 1987:181-26. | 9. Critchlow B. The powers of John Barleycorn. Beliefs about the effects of alcohol on social behavior. Am Psychol 1986;41(7):751-64. | 10. Leigh BC. In search of the seven dwarves: Issues of measurement and meaning in alcohol expectancy research. Psychol Bull 1989;105:361-73. | 11. Mulford H. Stress, alcohol intake and problem drinking in Iowa. In: Pohorecky LA, Brick J, eds. Stress and Alcohol Use, Proceedings of the First International Symposium on Stress and Alcohol Use. New York: Elsevier, 1983:321-32. | 12. Farber PD, Khavari KA, Douglass FM. A factor analytic study of reasons for drinking: Empirical validation of positive and negative reinforcement dimensions. J Consult Clin Psychol 1980;48(6):780-81. | 13. Abrams DB, Niaura RS. Social learning theory. In: Blanc HT, Leonard KE, eds. Psychological theories of drinking and alcoholism. New York: Guilford Press, 1987:131-78. | 14. Folkman S, Lazarus RS. An analysis of coping in a middle aged community sample. J Health Soc Behav 1980; Sep 21(3):219-39. | 15. Moos RH, Finney JW, Chan DA. The process of recovery from alcoholism. I. Comparing alcoholic patients and matched community controls. J Stud Alcohol 1981 May;42(5):383-402. | 16. Moos RH, Finney JW, Gamble W. The process of recovery from alcoholism. II. Comparing spouses of alcoholic patients and matched community controls. J Stud Alcohol 1982 Sep; 43:888-909. | 17. Huffine CL, Folkman S, Lazarus RS. Psychoactive drugs, alcohol and stress and coping processes in older adults. Am J Drug Alcohol Abuse 1989;15:101-13. | 18. Folkman S, Bernstein L, Lazarus RS. Stress processes and the misuse of drugs in older adults. Psychol Aging 1987;2:366-74. | 19. Cooper ML, Rusell M, Skinner JB, Frone MR, Mudar P: Stress and alcohol use: Moderating effects of gender,coping and alcohol expectancies. J Abnorm Psychol 1992;101(1):139-52. | 20. Marlatt GA, Kosturn CF, Lang AR. Provocation to anger and opportunity for retaliation as determinants of alcohol consumption in social drinkers. J Abnorm Psychol 1975;84:652-59. | 21. Higgins RL, Marlatt GA. Fear of interpersonal evaluation as a determinant of alcohol consumption in male social drinkers. J Abnorm Psychol 1975;84:644-51. | 22. Hull JG, Young RD. Self-consciousness, self-esteem, and success-failure as determinants of alcohol consumption in male social drinkers. J Pers Soc Psychol 1983;44:1097-09. | 23. Billings AG, Moos RH. Psychosocial processes of recovery among alcoholics and their families: Implications for clinicians and program evaluators. Addict Behav 1983;8(3):205-18. | 24. Miller WR, Hester RK. Treatment: What research reveals. In: Miller WR, Heather N, eds. Treating addictive behaviors. New York: Plenum Press, 1986:121-74. |