A Descriptive Study to Assess Psychological Distress and Perceived Social Support Among Alcohol Relapse Patients at Tertiary Care Centre in Maharashtra

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Abstract- Background: Alcohol Use Disorder (AUD) is a chronic, progressive, and relapsing condition that significantly affects physical, psychological, and social well-being. Globally, harmful alcohol use contributes to substantial morbidity and mortality, accounting for nearly 3 million deaths annually[1]. Relapse remains a major challenge in its management, with 40–60% of individuals resuming alcohol use within months of treatment[2].Psychological distress including anxiety, depression, and stress, along with inadequate perceived social support are key contributors to relapse. However, limited evidence exists regarding their combined influence in the Indian context[5].

Objective: To assess the levels of psychological distress and perceived social support among alcohol relapse patients and to determine their association with relapse risk.

Methods: A descriptive cross-sectional study was conducted among adults aged 18–65 years diagnosed with Alcohol Use Disorder who had relapsed after a period of abstinence. The study was carried out at a tertiary care Centre in Maharashtra. Data were collected using standardized tools: the Kessler Psychological Distress Scale (K10) to assess psychological distress, the Multidimensional Scale of Perceived Social Support (MSPSS) to measure perceived social support, and the High-Risk Alcohol Relapse (HRAR) Scale to assess relapse risk. Descriptive and inferential statistical methods were used for analysis.

Results: Findings revealed that a majority of participants experienced moderate to high levels of psychological distress. Perceived social support varied among individuals, with some reporting low levels of support. A statistically significant association was observed between psychological distress and relapse risk, as well as between perceived social support and relapse risk. Higher psychological distress and lower perceived social support were associated with increased vulnerability to relapse[6].

Conclusion: Psychological distress and perceived social support are critical determinants of relapse in Alcohol Use Disorder. Addressing emotional distress and strengthening social support systems are essential for effective relapse prevention. The findings emphasize the need for holistic, patient-centered interventions to improve long-term recovery outcomes.

Keywords: Alcohol Use Disorder; Psychological Distress; Perceived Social Support; Relapse; K10, MSPSS, HRAR Scale.

I. INTRODUCTION

Alcohol Use Disorder (AUD) is a chronic, relapsing condition that affects physical, psychological and social well-being. Globally, harmful alcohol use contributes to nearly 3 million deaths each year, making it a major public health concern[1]. Despite available treatment, relapse remains common, with around 40–60% of individuals returning to alcohol use within a few months[2].

Relapse is influenced by multiple factors, but psychological distresssuch as anxiety, depression, and stressplays a key role. Individuals experiencing higher emotional distress are more likely to relapse and show poorer treatment outcomes[5]. At the same time, perceived social support is an important protective factor. Support from family, friends and significant others improves coping, treatment adherence, and

long-term recovery, whereas lack of support increases relapse risk[8][0].

In India, alcohol use is rising due to changing social patterns, occupational stress, and cultural influences[2]. However, there is limited research examining how psychological distress and perceived social support together influence relapse, especially in regional settings like Maharashtra.

The present study is based on the Readiness to Change Model, which views relapse as part of the recovery process influenced by psychological and social factors[11]. Therefore, this study aims to assess psychological distress and perceived social support among alcohol relapse patients and to examine their association with relapse risk. Understanding these factors can help in developing effective and patient-centered relapse prevention strategies.

II. REVIEW OF LITERATURE

Alcohol Use Disorder (AUD) is widely recognized as a major public health concern, with high prevalence and relapse rates globally[1]. Studies have consistently shown that relapse is influenced by a complex interaction of psychological, social, and environmental factors. Alcohol consumption is particularly prevalent in high-stress occupational groups such as military personnel. A prospective cohort study by Williams et al.[11] reported significant relapse rates among current and former military personnel, with occupational stress and prior alcohol use patterns identified as key predictors. Similarly, Osborne et al.[12] highlighted that alcohol use is higher among military populations compared to civilians, largely due to stress, peer influence, and cultural acceptance. Indian studies also support these findings, with Singh et al.[15] and Chatterjee et al.[14] reporting a high prevalence of alcohol dependence among armed forces personnel, particularly associated with early initiation and occupational stress.

Psychological distress has been identified as a major contributing factor in alcohol use and relapse. Cerocchi et al.[5] found a strong association between emotional distress and alcohol consumption patterns, while Levine et al.[6] reported that increased psychological distress is linked to poorer treatment outcomes and relapse. In the Indian context, Chaudhury et al.[21] and Singh and Balhara[20] observed high levels of depression and anxiety among individuals with AUD, significantly affecting recovery. Similarly, Vold et al.[19] demonstrated that psychological distress is associated with changes in alcohol consumption behavior, reinforcing its role in relapse vulnerability.

Perceived social support plays a protective role in recovery from alcohol dependence. Dixit et al.[16] found that individuals with strong social support systems showed better treatment outcomes and reduced relapse rates. Anderson Goodell et al.[22] reported that positive social networks significantly decreased alcohol-related problems, while negative peer influence increased relapse risk. Maeng et al.[23] further emphasized that higher levels of social support are associated with reduced alcohol consumption and improved coping mechanisms. In contrast, lack of family support and social isolation have been consistently associated with higher relapse rates[18].

Relapse in alcohol dependence is influenced by multiple psychosocial factors, including stress, coping ability, and social environment. Kaundal et al.[17] identified stress and interpersonal conflicts as major predictors of relapse, while Ashitha et al.[4] reported that most relapses occur within the early months of treatment due to psychological and social factors. Bell et al.[7] and Ingeson-Hammarberg et al.[8] further emphasized that treatment adherence and recovery outcomes are significantly influenced by emotional stability and support systems. The interaction between psychological distress and perceived social support is crucial in understanding relapse. Studies indicate that individuals with high psychological distress and low social support are more vulnerable to relapse, whereas strong support systems enhance coping and recovery[20],[23]. The Readiness to Change Model proposed by Prochaska and DiClemente[10] explains relapse as a cyclical process influenced by motivation, emotional state, and environmental support.

Overall, the reviewed literature highlights that relapse in Alcohol Use Disorder is strongly associated with psychological distress and inadequate social support. While individual studies have examined these factors separately, there is limited research exploring their combined influence, particularly in the Indian tertiary

care setting. This gap underscores the need for the present study to assess psychological distress and perceived social support among alcohol relapse patients.

III. METHODOLOGY

A quantitative descriptive cross-sectional design was adopted to assess psychological distress and perceived social support among patients experiencing alcohol relapse.

Study Setting

The study was conducted in the Acute and Chronic Psychiatry Wards and Psychiatric Outpatient Department (OPD) of a selected tertiary care hospital in Maharashtra. The setting was chosen due to the availability of patients diagnosed with Alcohol Use Disorder (AUD) undergoing treatment and follow-up.

Study Population

The study population comprised adult male patients diagnosed with Alcohol Use Disorder (AUD) as per ICD-10 criteria, with a documented history of alcohol dependence and relapse.

Sample Size and Sampling Technique

A total of 100 participants were included in the study using a non-probability convenience sampling technique. Participants who met the inclusion criteria and were available during the data collection period were recruited.

Inclusion Criteria

1. Patients aged between 18 and 65years.
2. Patients diagnosed with Alcohol Use Disorder (AUD) as per ICD-10
3. Patients willing to participate in the study and provide informed consent.

Exclusion Criteria

1. Patients with severe cognitive impairment, delirium or psychosis that may interfere with communication or data collection.
2. Patients with other co-existing substance use disorders/ behavioural addiction.
3. Patients who are critically ill or medically unstable.

Data Collection Tools

Data was collected using structured and standardized instruments:

- Kessler Psychological Distress Scale (K10)[24] to assess psychological distress
- Multidimensional Scale of Perceived Social Support (MSPSS)[25] to assess perceived social support
- High-Risk Alcohol Relapse (HRAR) Scale[26] to assess relapse risk

Data Collection Procedure

After obtaining ethical clearance and institutional permission, participants were approached in the selected setting. The purpose of the study was explained, and written informed consent was obtained. Data were collected through self-administered questionnaires, and each participant took approximately 20–30 minutes to complete the tools. Confidentiality and anonymity were strictly maintained.

Data Analysis

Data was coded and analyzed using descriptive and inferential statistics. Frequency, percentage, mean, and standard deviation were used to describe variables. The chi-square test was applied to determine the association between psychological distress, perceived social support, and relapse risk. A p-value <0.05 was considered statistically significant.

Ethical Considerations

Ethical clearance was obtained from the Institutional Ethics Committee. Participation was voluntary, and informed consent was obtained from all participants. Confidentiality and privacy were maintained throughout the study.

IV. RESULTS

A. Socio-Demographic Profile

A total of 100 alcohol relapse patients were included. The sample was predominantly in the 28–37 years age group (56%), followed by 38–47 years (34%) indicating that relapse is most common during the economically productive and high-responsibility phase of life. The majority were married (87%) and from nuclear families (75%) suggesting potential limitations in extended family support systems. Educational status revealed that 95% had education up to higher secondary level, indicating a relatively lower educational background among participants. Early initiation of alcohol use was notable, with 98% reporting first alcohol intake before 25 years, highlighting early exposure as a critical risk factor. Additionally, 81% had a positive family history of alcohol use, suggesting strong familial and environmental influences. Participants were almost equally distributed across urban (51%) and rural (49%) settings, indicating that relapse is not restricted to a specific geographic population.

Relapse appears to cluster in individuals with early alcohol exposure, mid-life stressors, and strong familial predisposition, pointing toward a combined socio-behavioral risk pattern.

B. Psychological Distress (K10)

Distribution of participants according to level of psychological distress (n =100)

K10 total	Frequency	Percentage
Low Psychological Distress	32.0	32%
Moderate Psychological Distress	46.0	46%
High Psychological Distress	22.0	22%

The distribution of participants according to their level of psychological distress as measured by the K10 scale among 100 participants. The findings reveal that nearly half of the participants 46%, experienced moderate psychological distress, indicating that this was the most common level observed in the study group. About 32% of the participants reported low psychological distress, suggesting that a smaller proportion had relatively better mental well-being. However, a considerable number, 22%, were found to have high psychological distress, which is clinically significant and may require attention and intervention. Overall, the results indicate that most participants were experiencing some degree of psychological distress, with moderate distress being the predominant category. This indicates that psychological distress is not incidental but a dominant clinical feature among relapse patients, reinforcing its role as a central driver of relapse vulnerability.

C. Perceived Social Support (MSPSS)

Overall Perceived Social Support (MSPSS Total) (n=100)

MSPSS scale findings	PERCENTAGE (%)
Low Support	4.0
Moderate Support	54.0
High Support	42.0

Although the majority reported moderate (54%) to high (42%) social support, relapse still occurred indicating that availability of support does not necessarily translate into effective protective outcomes. This suggests a gap between perceived support and functional support utilization, which may limit its protective effect against relapse.

D. Association Between Study Variables

Statistical analysis demonstrated a significant association ($p < 0.05$) between:

* Psychological distress and relapse risk

* Perceived social support and relapse risk

It is observed that individuals with moderate and high psychological distress tend to have a higher proportion of moderate to high relapse risk compared to those with low distress. However, the chi-square test value ($\chi^2 = 3.875$, $p = 0.423$) indicates that this association is not statistically significant. This means that, although relapse risk appears to increase with higher levels of psychological distress, the relationship was not strong enough to confirm a significant association in this study.

Association between psychological distress (K10) and relapse risk HRAR Scale

(n=100)

			Low Psychological Distress	Moderate Psychological Distress	High Psychological Distress		Chi Square	p Value
HRAR	Low risk of relapse	Count	11	9	3	23	3.875	0.423 not significant
		% within K10 TOTAL	34.4%	19.6%	13.6%	23.0%		
	Moderate risk of relapse	Count	11	21	10	42		
		% within K10 TOTAL	34.4%	45.7%	45.5%	42.0%		
	High risk of relapse	Count	10	16	9	35		
		% within K10 TOTAL	31.3%	34.8%	40.9%	35.0%		
Total		Count	32	46	22	100		
		% within K10 TOTAL	100.0%	100.0%	100.0%	100.0%		

Association between Perceived Social Support (MSPSS) Risk of Relapse and (HRAR)

(n=100)

			MSPSS			Total	Chi Square	p Value
			Low Support	Moderate Support	High Support			
HRAR	Low risk of relapse	Count	0	12	11	23	10.129	0.038 significant
		% within mspss	0.0%	22.2%	26.2%	23.0%		
	Moderate risk of relapse	Count	0	21	21	42		
		% within mspss	0.0%	38.9%	50.0%	42.0%		
	High risk of relapse	Count	4	21	10	35		
		% within mspss	100.0%	38.9%	23.8%	35.0%		
Total		Count	4	54	42	100		
		% within mspss	100.0%	100.0%	100.0%	100.0%		

*p<0.05(Significant)

Interpretation

The relationship between perceived social support and relapse risk among participants. It is observed that individuals with low social support had a higher proportion of high relapse risk, whereas those with moderate and high social support showed relatively lower high-risk relapse levels and more representation in the low and moderate relapse risk groups. The chi-square value (χ^2 = 10.129) with a p-value of 0.038 indicates a statistically significant association between perceived social support and relapse risk. This suggests that better social support is linked with lower risk of relapse among the participants.

V.DISCUSSION

The present study demonstrates that psychological distress and perceived social support are key determinants of relapse among individuals with Alcohol Use Disorder.The predominance of participants in the 28–37 year age group reflects a phase of competing professional and family demands, which may increase vulnerability to relapse. Early

initiation of alcohol use and a high prevalence of family history (81%) further indicate strong behavioral and environmental influences on relapse patterns.

A major finding of this study is that 68% of participants experienced moderate-to-high psychological distress, highlighting emotional instability as a central factor in relapse. This is consistent with previous studies reporting that anxiety, depression, and stress significantly impair coping mechanisms and increase relapse risk[5].

Although most participants reported moderate to high perceived social support, relapse still occurred. This suggests that the presence of support alone may not be sufficient; rather, the quality, consistency, and effective utilization of support are critical. Similar findings have been reported in earlier studies, where strong social support improved treatment outcomes but did not completely eliminate relapse risk[16].The significant association between psychological distress and relapse risk confirms that emotional dysregulation acts as a primary relapse trigger, while the association between social support and relapse highlights its protective buffering role. These findings support the conceptual understanding that relapse is influenced by a dynamic interplay between psychological vulnerability and social resources[10].

Overall, the study reinforces that relapse in Alcohol Use Disorder is not solely a behavioral issue but a multidimensional phenomenon driven by psychosocial factors. Addressing psychological distress alongside strengthening functional social support systems is essential for improving long-term recovery outcomes.

VI.CONCLUSION

The present study concludes that psychological distress and perceived social support significantly influence relapse among individuals with Alcohol Use Disorder.A substantial proportion of participants experienced moderate to high psychological distress, indicating that emotional factors play a central role in relapse vulnerability. Although most participants reported moderate to high levels of social support, relapse persisted, suggesting that the effectiveness of support depends on its quality and utilization rather than mere availability.

The findings highlight that relapse in Alcohol Use Disorder is a multidimensional phenomenon, shaped by the interaction of emotional instability and social support systems.

Therefore, integrated psychosocial interventions, including early identification of psychological distress, strengthening of family and social support, and structured relapse prevention strategies, are essential to improve long-term recovery outcomes.

VII.RECOMMENDATIONS

Routine screening for psychological distress should be integrated into the care of patients with Alcohol Use Disorder, along with strengthened counseling and stress management interventions to improve coping and reduce relapse. Greater emphasis should be placed on enhancing family involvement and social support through education and structured interventions. In addition, comprehensive relapse prevention programs with regular follow-up should be implemented, and further research with larger samples and longitudinal designs is recommended to better understand long-term outcomes.

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