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Addiction Patient's Relationship to Self and Predictions on the Estimated Hospitalization Duration

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Abstract: *Addictions are physical and/or psychological dependency disorders characterized by repetitive and compulsive behaviours in which the individual has difficulty controlling impulses. In this study, behaviours are defined as chronic alcohol or substance use. Thus, compulsions will generate negative consequences on a person's quality of life. Among the causes of addiction are genetic and biological factors, environmental factors, trauma, abuse, lack of emotional support, stress, social pressures, poor coping mechanisms, social and cultural factors.*

Material and method

In this study, part of a larger study, 81 patients diagnosed with toxic-nutritional liver cirrhosis, chronic alcohol users, aged between 32 and 68 years were included. The study period was of two years, and anamnestic data (number of hospitalization days, hospitalization frequency) were collected for the period 2015-2022. In order to carry out the linear research, SPSS statistical software was used. Patients, after obtaining consent, were administered a psychological questionnaire designed to assess unconditional self-acceptance, based on the hypothesis that low self-tolerance generates self-destructive behaviours, i.e. addictions.

Results

The necessary statistical steps were followed in order to check the database and it was possible to obtain correlations between the number of hospitalization days, the hospitalization frequency and the scores obtained in the questionnaire. Finally, it was possible to generate a simple linear regression prediction with the number of hospitalisation days /inpatient frequency as the dependent variable and the test score as the independent variable.

The results showed that as unconditional self-acceptance decreases (decreasing score), the hospitalization duration or the number of patient presentations to the doctor increases.

Conclusions

Unconditional self-acceptance, environmental tolerance, coping mechanisms have a major impact on the patient's well-being and compliance with treatment. Psychosomatic disorders accompany the addiction patient to a much greater extent than the diagnosis made by clinicians. This demonstrates the need for a diagnostic tool, the lack of collaboration with the psychiatrist, ultimately generating costs on the health system and reducing the quality of the patient's life.

In order to optimise the diagnosis, a tool within the clinician's reach (internal medicine doctor, gastroenterologist, etc.) and a real collaboration with the psychiatrist or clinical psychologist is necessary.

Keywords: *addictions, predictions, liver cirrhosis, psychosomatic disorders, unconditional self-acceptance.*

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Patient self-report of addiction and predictions of estimated length of hospitalisation

Introduction

Dependence or addiction is a mental and physical disorder characterized by a compulsive need to consume a substance or engage in a particular behaviour, despite the associated negative consequences.

Anyone can suffer from an addiction: addiction to alcohol, tobacco, drugs, shopping, but also addiction to movies, literature, beauty and love. When addictions strictly affect the individual, by generating somatic pathologies, we may not have the right to get involved or judge. But when it affects those around them, the social and family environment, addiction becomes a problem that can no longer be ignored.

In this paper, the addictions referred to are strictly related to alcohol consumption.

Alcohol consumption in Europe is higher than in other parts of the world. According to the WHO, the annual per capita alcohol consumption in 2016 was 9.8 litres of alcohol, compared to the global average of 6.4 litres. The data has not been updated due to the 2020 pandemic, with updated statistics likely to be published.

According to the same studies, 35.4% of Romanians reported drinking alcohol in the last month and 9.3% reported drinking alcohol frequently throughout their lives.

Worryingly, Romania is the top country in the European Union for binge drinking, with 8.2% of Romanians reporting drinking five or more alcoholic drinks on a single occasion, at least monthly.

Alcohol addiction in Romania is a public health problem. The financial, social and psychological implications of this state of affairs cannot be estimated.

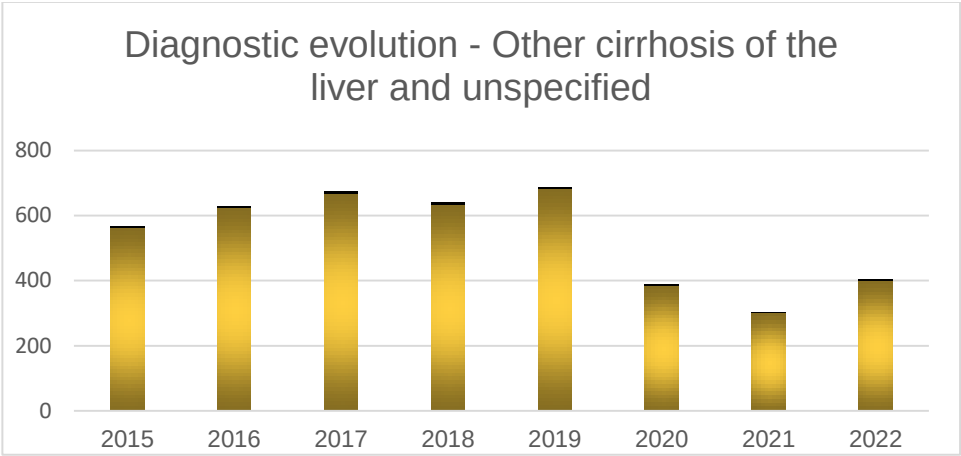


Figure 1 - Diagnosis of liver cirrhosis/year - S.C.J.U. Galați
Source: Authors' personal data

The most common complication of alcohol abuse is toxic-nutritional liver cirrhosis, followed by pancreatitis, gastric and duodenal ulcers, metabolic disorders, hypertension, chronic heart failure, psychiatric disorders, road trauma, etc.

Considering that society does not blame alcohol consumption, especially in rural areas, that prophylaxis is difficult to achieve, being about the need for social re-education and emotional development, the doctor is often confronted with the alcohol-dependent patient in the final stages of toxic-nutritional liver cirrhosis.

According to recent psychological studies, addictions are caused by emotional pain. Lack of love and emotional support in childhood will have dramatic consequences for the adolescent and adult. Unfortunately, many times a parent confuses attention with the emotional availability offered to the child. Thus, an adult with accepted or not, conscious or not, emotional pain will use an anaesthetic in the form of addiction. Certainly, no one consumes alcohol except with the aim of forgetting, of being socially accepted, of dampening a trauma, a fear, a desire. At the same time, the individual who chooses this path is also the one who has no other solution, with the emotional tools he possesses.

The abuse-prone personality is the personality lacking differentiation. *Differentiation* is the ability to be self-aware while interacting with others. Babies lack this ability in the first months of life. Self-awareness occurs late in the development and is absent in the animal kingdom. In other words, lack of emotional maturity will generate addictive behaviours. Is the alcoholic patient's image of self and world distorted? Is it similar to a

newborn's image of the world in some respects? And here we refer to the fear that a helpless child feels towards the world.

Material and method

81 patients with a diagnosis of nutritional toxic liver cirrhosis were included in this study, with special care not to interview people with a history of hepatic encephalopathy and people over 70 years of age. The study was based on data from 2015-2022 on the number of hospitalization days and frequency of presentation to "Sf. Ap. Andrei" Emergency Clinical Hospital Galati.

Abiding by the legislation in force regarding data confidentiality, ethics and morality of clinical studies, after obtaining the agreements of the health unit and the Ethics Commission, the psychological study was started.

These patients were administered a questionnaire from the Clinical Evaluation System - Unconditional Self-Acceptance Questionnaire (USAQ), license number AB series 0724.

The USAQ questionnaire aims to assess the relationship with the self. Behaviours towards the environment are generated by self-esteem. In this sense, low self-esteem correlates with depression, while very high self-esteem correlates with aggression towards others. Assessment is based on acceptance of individual imperfections. Do I accept myself even if I am not perfect? Do I consider myself perfect? Evaluation refers to behaviours generated by self-image. The questionnaire assesses behaviours, not what the individual is.

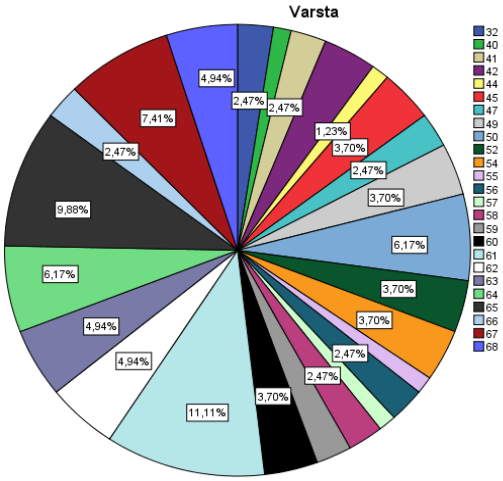
The questionnaire consists of 20 questions, is designed in 2001 by Chamberlain in The Hague, the total score can be a minimum of 20 points and a maximum of 140 points. Scoring is straightforward for 9 items and reverse for 11 items.

The choice of patients for the study was based on subjective observations of patient self-esteem, often observing in practice that addicts try to excuse their addiction by referring to the hostile environment or lack of self-worth.

Illustration of the composition of the group of subjects

The surveyed group of 81 male and female patients aged between 32 and 68 years was followed over a period of 8 years, from 2015-2022, using the information base of the health unit: "St. Apostle Andrew" Emergency Clinical County Hospital.

Data on gender, age, hospitalization frequency, number of hospitalization days (8 years cumulative), associated diagnosis for each patient interviewed were recorded in a database created in Microsoft EXCEL and then retrieved in IBM SPSS together with the scores obtained in the USAQ questionnaire, scores that were divided into 5 categories under the name of *unconditional acceptance categories* (very poor, poor, average, high, very high).



The particularities of the surveyed group will be detailed below.
Source: Authors' personal data
Figure 2 - Distribution by CH age

Figure 2 shows the percentage distribution of the batch by age. The majority of the values are between the ages of 60-65, which tells us that addictions may have started in the first decade of life.

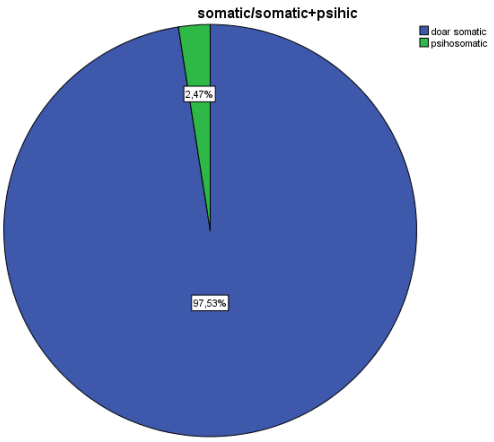


Figure 3 - Distribution by CH gender
Source: Authors' personal data

The gender composition of the batch is 56 men and 25 women. In clinical practice, the incidence of toxic-nutritional liver cirrhosis is high for the male gender.

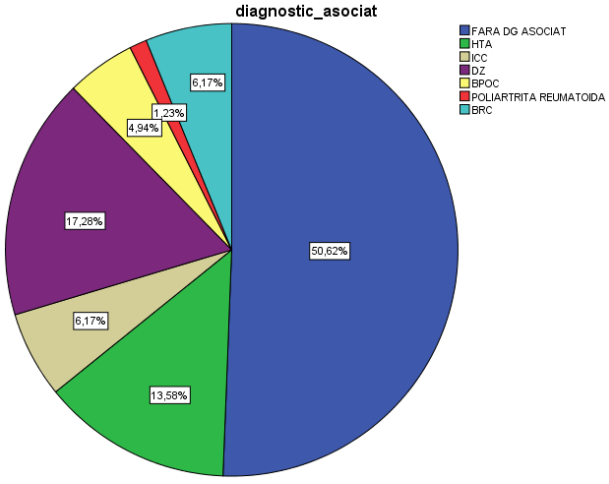


Figure 4 - Distribution by type of CH-diagnosis
Source: Authors' personal data

According to Figure 4, 2.47% of the subjects also have a diagnosis of psychosomatic disorder at discharge.

Not formulating a unidirectional research hypothesis, I opted for a horizontal analysis studying the correlation between liver pathology and 8 distinct pathologies in order of incidence.

Figure 5 shows that 50.6% of the patients interviewed do not yet associate any other diagnosis with liver cirrhosis, and 17.3% associate diabetes mellitus, while 11% associate hypertension with treatments already in place.

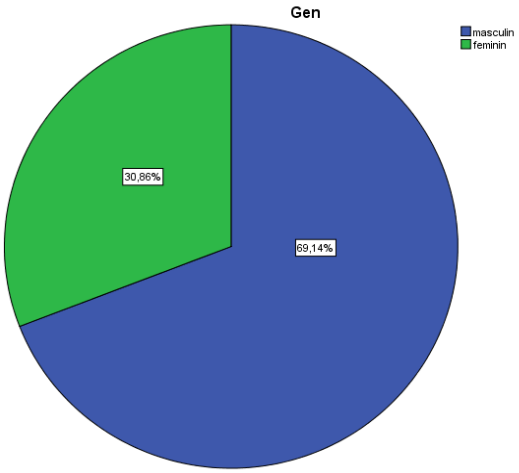


Figure 5 - Diagnosis associated with CH
Source: Authors' personal data

Results

Database checking and calculation of basic statistical indicators

The verification of the database is done by calculating the most important statistical indicators of the numerical variables subject to statistical analysis, such as: mean, median, standard deviation and Skewness and Kurtosis coefficient.

Source: Authors' personal data

Table 1 - Basic statistical CH indicators

		Age	Hospitalisation days (full data)	Unconditional Acceptance	Admission Frequency
N	Valid	81	81	81	81
	Missing	0	0	0	0
Mean		57,20	32.52	82.47	5.06
Median		61,00	32.00	82.00	5.00
Std. Deviation		9,012	13.000	2.860	2.576
Variance		81,210	169.003	8.177	6.634
Skewness		-.890	.093	.002	.353
Std. Error of Skewness		.267	.267	.267	.267
Kurtosis		-.030	-1.023	-.330	-.972
Std. Error of Kurtosis		.529	.529	.529	.529
Minimum		32	8	76	1
Maximum		68	58	89	11

An important aspect of descriptive analysis is the expression of the mean and median in terms of two variables, variables that will be passed through the layers of correlation and regression analysis.

Source: Authors' personal data

Table 2 - Variable – Hospitalization days by **Unconditional acceptance category** categorical variable

Hospitalisation days (full data)

Unconditional acceptance category	N	Mean	Median
low	50	40.46	41.50
average	31	19.71	20.00
Total	81	32.52	32.00

As we can see in Table 2 the variable *Hospitalization days* has mean and median with high values on the category of patients with low unconditional *self-acceptance*, with values of 40.46 and 41.50. This shows that the positive influence on the variable *Hospitalization days* is had by the low category (low scores).

In the present research it is of statistical interest whether there are correlations between the hospitalization frequency, i.e. the number of hospitalization days, and the categories generated by the scores obtained in the test of unconditional self-acceptance. To this end, the mean and median of the variables to be studied must be generated. Thus, the

highest mean = 6.28 and the median = 6.50 are found in the case of patients who obtained scores related to unconditional self-acceptance in the low-level category (see Table 3).

Table 3 - Variable – Admission frequency by categorical variable Unconditional acceptance category

Admission frequency

Unconditional acceptance category	N	Mean	Median
low	50	6.28	6.50
average	31	3.10	2.00
Total	81	5.06	5.00

Source: Authors' personal data

In conclusion, low unconditional self-acceptance could lead to multiple presentations to the doctor and increased length of hospitalisation.

Statistical hypothesis testing

Given the conclusions resulting from the association of the variables we can formulate two statistical hypotheses:

- H0 - no relationship between hospitalization days /hospitalization frequency and psychological questionnaire scores;
- H1 - there is a relationship between hospitalization days /hospitalization frequency and psychological questionnaire scores;

The batch of patients with a diagnosis of liver cirrhosis and addiction supports both hypotheses, but most importantly, we will investigate whether there is an underdiagnosis of psychosomatic disorders.

The hypothesis is bidirectional.

The significance threshold is set at 0.05 (or 5%).

Testing the normality of the collected data distribution

Testing the normality of the distribution of the data of the variables under analysis is important because it is based on the assumption that the data collected come from a normal distribution.

The normality of the distribution will be tested using the Kolmogorov-Smirnov test. The significance threshold $p>0.05$, demonstrates that the variable is normally distributed.

Table 4 - One-Sample Kolmogorov-Smirnov Test Age, Hospitalization days, Hospitalization frequency

		Age	Hospitalisation days (full data)	Admission frequency
N		81	81	81
Normal Parameters[a,b]	Mean	57.20	32.52	5,06
	Std. Deviation	9.012	13.000	2,576
Most Extreme Differences	Absolute	.182	.096	.154
	Positive	.115	.096	.154
	Negative	-.182	-.089	-.120
Kolmogorov-Smirnov Z		1.638	.868	1.384
Asymp. Sig. (2-tailed)		.009	.438	.043

a. Test distribution is Normal.
b. Calculated from data.

Source: Authors' personal data

Variables *age*, *hospitalization days* and *hospitalization frequency*, Kolmogorov-Smirnov value is >0.05, the data are normally distributed (according to Table 4).

Table 5 - One-Sample Kolmogorov-Smirnov Unconditional Acceptance Test

		Unconditional Acceptance
N		81
Normal Parameters[a,b]	Mean	82.47
	Std. Deviation	2.860
Most Extreme Differences	Absolute	.089
	Positive	.086
	Negative	-.089
Kolmogorov-Smirnov Z		.802
Asymp. Sig. (2-tailed)		.540

Source: Authors' personal data

From Table 5 it can be seen that the variable *unconditional* self-acceptance, Asymp. Sig. is >0.05, which means that the data are normally distributed.

Correlational analysis

The normal distribution and linearity of the variables allows us to study the size of the correlation effect between them. We will use Pearson's coefficient (r) to determine whether there are correlations between the

dependent variables: *hospitalization days*, *hospitalization frequency* and the independent variable: *unconditional acceptance*.

Table 6 - Correlation between Hospitalization days and Unconditional Acceptance

		Hospitalisation days (full data)	Unconditional Acceptance
Hospitalisation days (full data)	Pearson Correlation	1	-.982**
	Mr (2-tailed)		.000
	N	81	81
Unconditional Acceptance	Pearson Correlation	-.982**	1
	Mr (2-tailed)	.000	
	N	81	81

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Authors' personal data

Table 7 - Correlation between Admission Frequency and Unconditional Acceptance

		Admission frequency	Unconditional Acceptance
Admission frequency	Pearson Correlation	1	-.712**
	Mr (2-tailed)		.000
	N	81	81
Unconditional Acceptance	Pearson Correlation	-.712**	1
	Mr (2-tailed)	.000	
	N	81	81

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Authors' personal data

The 7 Pearson correlation tables generated by SPSS show us that there is an increasing correlation for *hospitalization days*, *hospitalization frequency* and decreasing unconditional self-acceptance.

Conclusion: A patient with low unconditional acceptance will have an increased hospitalization frequency and a higher estimated hospitalization duration, which also validates the research hypothesis.

Simple linear regression

The purpose of linear regression is to generate a prediction. We are interested at this point in finding out whether the occurrence of a psychosomatic disorder will lead to an increase in the number of

hospitalization days, i.e. an increase in the frequency of the patient's referral to the doctor.

Thus, we will be able to predict the score of the dependent variables: number of hospitalization days, hospitalization frequency according to the independent variable.

In linear regression, the dependent variable is the criterion and the independent variable is the predictor, being a model with a predictive purpose.

We generate reports in SPSS for bivariate linear regression for one dependent variable and one independent variable at a time.

Linear regression - *Days in hospital* and *USAQ* test values

Table 8 - Model Summary - Hospitalization days/Unconditional acceptance

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.982[a]	.964	.964	2.465

a. Predictors: (Constant), Unconditional Acceptance
b. Dependent Variable: Days in hospital (full data)

Source: Authors' personal data

Table 8 shows us by R=0.982, that there is a very strong correlation between the number of hospitalization days and USAQ test results.

R^2 = 0.964 - 96.4% of the variance in hospital days can be explained by the variance of unconditional acceptance.

The standard error of the estimate = 2.465 shows the accuracy of the model.

Table 9 - ANOVA – Hospitalization days/Unconditional acceptance

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	13040.147	1	13040.147	2145.856	.000[b]
	Residual	480.075	79	6.077		
	Total	13520.222	80			

a. Dependent Variable: Days in hospital (full data)
b. Predictors: (Constant), Unconditional Acceptance

Source: Authors' personal data

F =2145.856 explains that the prediction is not a chance, i.e. the results cannot be a sampling error. The significance threshold of the F-test shows us that the results are statistically significant Sig. < 0,05.

Table 10 - Coefficients - Hospitalization days/Unconditional acceptance

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	400.721	7.953		50.385	.000
	Unconditional Acceptance	-4.465	.096	-.982	-46.323	.000

a. Dependent Variable: Days in hospital (full data)

Source: Authors' personal data

Y= a+b·X = 400.721+(-4.465)·X = 400.721-4.465·80 = 400.721-361.665 = **43.521** hospital days for a patient with CH and somatization disorder (in 8 years) with a USAQ score = 80 units.

Beta = -.982, i.e., if unconditional acceptance decreases by one unit, hospital days increase by 0.982 standard deviations.

Table 11 - Residuals Statistics - Hospitalization days/Unconditional acceptance

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	3.36	61.40	32.52	12.767	81
Std. Predicted Value	-2.284	2.262	.000	1.000	81
Standard Error of Predicted Value	.278	.686	.372	.108	81
Adjusted Predicted Value	2.97	61.93	32.51	12.801	81
Residual	-6.401	4.640	.000	2.450	81
Residual Std.	-2.597	1.882	.000	.994	81
Stud. Residual	-2.702	1.960	.001	1.008	81
Deleted Residual	-6.930	5.030	.005	2.524	81
Stud. Deleted Residual	-2.818	1.996	-.002	1.021	81
Mahal. Distance	.027	5.216	.988	1.264	81
Cook's Distance	.000	.302	.015	.039	81
Centered Leverage Value	.000	.065	.012	.016	81

a. Dependent Variable: Days in hospital (full data)

Source: Authors' personal data

According to Field (2000), Std. Residual and Stud. Residual is in the range -3 and +3, the regression equation has no extreme cases.

Cook distance=0.302 means no influential cases.

Conclusion: simple linear regression results indicate that a predictive model can be created between the variable of unconditional self-acceptance and the number of hospital days.

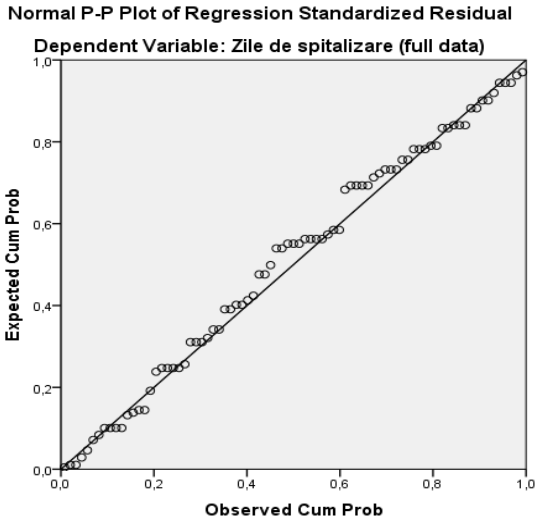


Figure 6 - Normal P-P plot Days in hospital/ Unconditional acceptance
Source: Authors' personal data

Linear regression between VD *Admission frequency and* VI *USAQ* test values

Table 12 - Model Summary - Frequency of admission/non-universal acceptance

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.712[a]	.507	.500	1.821

a. Predictors: (Constant), Unconditional Acceptance
b. Dependent Variable: Frequency of admission

Source: Authors' personal data

Table 12 shows that there is a very strong correlation between *admission frequency* and USAQ scores with R=0.712.

R^2 = 0.507 - 50.7% of the variance in admission frequency can be explained by the variance of unconditional acceptance.

The standard error of the estimate =1.821 shows the accuracy of the model.

Table 13 - ANOVA - Frequency of admission/Unconditional acceptance

Model		Sum of Squares	df	Mean Square	F	Mr
1	Regression	268.814	1	268.814	81.093	.000[b]
	Residual	261.877	79	3.315		
	Total	530.691	80			

a. Dependent Variable: Frequency of admission
b. Predictors: (Constant), Unconditional Acceptance

Source: Authors' personal data

F = 81.093 explains that the prediction is not a chance, i.e. the results cannot be a sampling error. The significance threshold of the F-test shows us that the results are statistically significant Sig. < 0,05.

Table 14 - Coefficients - Intake frequency/Unconditional acceptance

Model		Unstandardized Coefficients		Standardized Coefficients	t	Mr
		B	Std. Error	Beta		
1	(Constant)	57.927	5.874		9.862	.000
	Unconditional Acceptance	-.641	.071	-.712	-9.005	.000

a. Dependent Variable: Frequency of admission

Source: Authors' personal data

Y = a+b·X = 57,927+(-0,641)· X = 57,927 - 0,641·80 = 57,927 - 51,28 = **6,647** number of admissions for a patient with CH and somatization disorder (in 8 years) with a USAQ score = 80 units.

Beta = -.712, i.e., if unconditional acceptance decreases by one unit, admission frequency increases by 0.712 standard deviations.

Table 15 - Residuals Statistics - Inpatient Frequency/Non-limited Acceptance

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	.88	9.21	5.06	1.833	81
Std. Predicted Value	-2.284	2.262	.000	1.000	81
Standard Error of Predicted Value	.205	.507	.275	.080	81
Adjusted Predicted Value	.86	9.39	5.06	1.841	81
Residual	-3.286	4.638	.000	1.809	81
Residual Std.	-1.805	2.547	.000	.994	81
Stud. Residual	-1.833	2.563	-.001	1.005	81
Deleted Residual	-3.390	4.697	-.003	1.852	81
Stud. Deleted Residual	-1.861	2.660	.002	1.015	81
Mahal. Distance	.027	5.216	.988	1.264	81
Cook's Distance	.000	.067	.012	.016	81
Centered Leverage Value	.000	.065	.012	.016	81

a. Dependent Variable: admission frequency

Source: Authors' personal data

Residual Std. and Stud. Residual is in the range -3 and +3, the regression equation has no extreme cases.

Cook's distance = 0.067 means no influential cases.

Conclusion: simple linear regression results indicate that a predictive model can be created between the variable of unconditional self-acceptance and admission frequency.

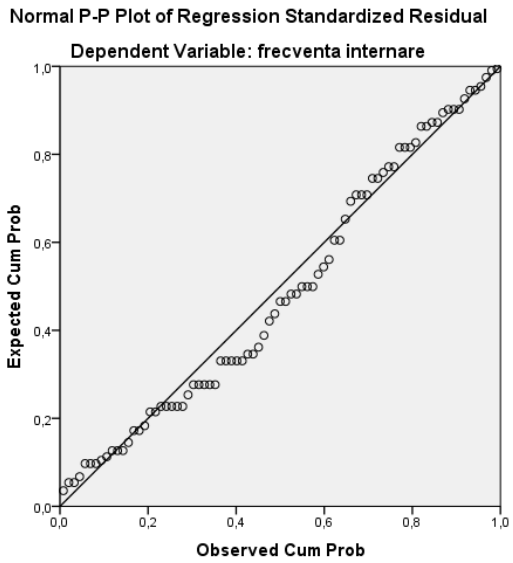


Figure 7 - Normal P-P Plot - Intake Frequency/Unconditional Acceptance
Source: Authors' personal data

According to the data resulting from the statistical analysis, we can affirm a strong and predictable relationship between hospitalization days, hospitalization frequency and USAQ results. Thus, the lower the USAQ score, the higher the number of hospitalization days and the higher the hospitalization frequency.

Discussion and conclusions

- Low self-acceptance will lead to multiple visits to the doctor and more days in hospital.
- Simple linear regression predictions between the influence of low unconditional self-acceptance and increased hospital days are significant.
- Simple linear regression predictions between the influence of low unconditional self-acceptance and frequency of admission are significant.

Considering that for the risk of bleeding, for the risk of falling, thromboembolic risk, haemorrhagic risk, etc. we have warning tools, it is pertinent to ask: For the risk of developing a psychosomatic pathology do we have a warning tool? For the risk of developing addictions do we have a diagnostic tool?

We all know at least one person with an addiction. We all have at least one addiction, with more or less environmental influence. Consequently, we certainly want the patient with addictions to be helped, understood, accepted, supported.

For the health system it is necessary to modify the case management plan of the patient with addictions, the settlement of support therapy sessions, the addition of specialized staff in hospitals (clinical psychologist and psychiatrist).

AMDP Psychiatric Assessment System - is a documentation system that was developed to produce a complete history, and has been constantly revised. (Bauman, 1983)

AMDP (Arbeitsgemeinschaft fur Methodik und Dokumentation in der Psychiatrie) covers a wide range of psychiatric symptoms and manifestations, including symptoms of *psychosomatic disorders and psychosomatic pathologies*.

The flexibility of the AMDP system makes it well suited for research and for evaluating the quality of health services.

For the assessment of the psychosomatic condition AMDP - proposes the following benchmarks:

- *Sleep and alertness disorders*
- *Appetite disorders*
- *Gastrointestinal disorders*
- *Cardiorespiratory disorders*
- *Other vegetative disorders*
- *Neurological disorders*

As far as psychiatric assessment is concerned, given that only a professionally trained person with extensive experience in the field can make a relevant assessment, we propose to continue research in order to develop tools that allow not the diagnosis, but at least the suspicion of psychosomatic disorder for specialist treatment.

Addiction prevention means love, tolerance, emotional support.

The physical body adapts to the environment only to the extent that the psyche can. We live in times of adaptation, of change, and maybe...just maybe.... we resist the environment with such force that cancer (from an immunity perspective) has become the nightmare of the 21st century, trauma a natural state, the environment so hostile that addiction has become for too many people the only chance of oblivion and the illusion of escape. Maybe if we adapt, we survive, maybe if we stop, we heal.

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