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Who seeks treatment for alcohol problems? Demography and alcohol-use characteristics of patients in taboo and non-taboo drinking groups attending professional alcohol services in Nepal

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ABSTRACT

Introduction: Only few individuals with alcohol problems seek help; those who do have not been described adequately. Here, we summarize the demographic and alcohol-related features of inpatients attending professional alcohol services in Nepal and examine differences between patients with and without social taboos about drinking.
Methods: Fully structured interviews including the Composite International Diagnostic Interview and the Alcohol Use Disorder Identification Test were administered to 177 men and 21 women consecutively admitted to eight alcohol treatment centres in Kathmandu.
Results: Altogether, 164 patients (83%) had alcohol dependence and 24 patients (12%) had alcohol abuse. The sample had a mean age of 35.3 years (SD 10.1) with a time lag of 16.8 years (SD 9.8) from start of habitual drinking to first entry into treatment. Most (62%) were married, lived in urban areas (72%), had above-average income (57%), received adequate social support (71%), and belonged to social groups in which drinking is taboo (57%). Individuals in non-taboo group more often lived in urban areas, had lower socioeconomic status, more often reported parental problem drinking and started drinking at a younger age, whereas individuals in the taboo group more often had late onset, risky drinking, and waited longer before seeking treatment ($P < 0.05$).
Conclusion: Traditionally alcohol non-using castes and people with higher socioeconomic status over-represent professional alcohol services in Kathmandu. This, and high levels of hazardous and harmful alcohol use, indicate changing trends concerning social tolerance towards alcohol in Nepalese society in recent times and a heavy burden associated with alcohol disorders.

1. Introduction

Individuals with alcohol-use disorders (AUDs) benefit substantially from participating in alcohol treatment, be it in the form of brief intervention (Vasilaki et al., 2006; McQueen et al., 2011), mutual help groups (Pagano et al., 2013; Moos and Moos, 2006) or specialized programmes (Room et al., 2005). Data from developed countries show that as few as a quarter of individuals with AUDs ever seek professional help (Hasin et al., 2007; Teesson et al., 2006). Developing countries suffer a double burden with steadily increasing alcohol consumption and even lower levels of treatment use (Wang et al., 2008; World Health Organization, 2004). South Asia has a particularly high prevalence of AUD per alcohol user (Rehm et al., 2009). Low treatment participation in India has reportedly been caused by lack of awareness, lack of treatment facilities and feelings of shame (Pal et al., 2003; Prasad, 2009). While large-scale population-level studies are required to evaluate treatment-seeking behaviour, smaller descriptive studies based on treatment populations have the potential to delineate various socio-demographic and clinical characteristics that determine such behaviours.

Typically, alcohol-treatment populations are described as adults who have lower socio-economic status and who show severe alcohol dependence features and complex isolated or comorbid psychopathology (Proudfoot and Teesson, 2002; Hasin and Glick, 1992; Ilgen et al., 2011). Studies from the USA have

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shown positive associations between lower income and educational levels and participation in treatment (Weisner and Matzger, 2002; Hasin et al., 2007). These associations may not hold for non-Western settings because of the differences in health systems and social contexts. For example, the users of hospital-based alcohol services in India and Nepal were found to be mainly middle-aged men belonging to the higher castes and those with higher education and income levels who were mostly confronting alcohol withdrawal (Pradhan et al., 2008; Pandey et al., 2012; Bhalla et al., 2006).

Nepalese society traditionally has an ambivalent relationship to alcohol. People belonging to the *Tagadhari* community were not supposed to drink, but no such taboo existed for the *Matawalis.* Tagadhari men are supposed to wear sacred thread around their body and, in their culture, use of alcohol is seen as a 'filthy' act. Historically, Tagadharis have been the ruling class and represent the upper stratum in the Hindu caste system. Among Matawalis, on the other hand, the use of alcohol has been accepted or even banalized in some groups. This group represents a relatively less affluent stratum of the society. With the modernization and socio-political transformation of Nepal over the past few decades, these distinctions may be fading, with increasing overlap in both the socio-economic status and alcohol use across these groups (Lawoti and Pahari, 2010). However, a national study conducted in 2000 showed that lifetime abstinence rates were 85% in the Tagadharis compared to 45% among Matawalis (Dhital et al., 2001), suggesting that the ambivalent attitude is still reflected in the society.

Adult per capita consumption of alcohol in Nepal was reported at 2.4 L of pure alcohol in 2003–2004, similar to the regional average of 2.2 L in South-East Asia (World Health Organization, 2004). Evidence indicates that as many as a quarter of the adult population in some urban areas needs evaluation for alcohol dependence. Under-age drinking is common, and home-brewing is rampant in Nepal (Jhingan et al., 2003; Dhital et al., 2001). These issues render alcohol an important concern in Nepal. This setting is resource constrained and fewer government-run services and an increasing number of privately run modified 12-step-based treatment programmes are to be found. However, patients generally need to pay for the treatment and not much is known about these patients. To fill this knowledge gap, we aimed to describe the socio-demographic and alcohol-related characteristics of patients attending eight different alcohol-treatment centres in Kathmandu. The second aim was to examine the differences between groups defined by social taboos about alcohol use within this population.

2. Methods

2.1. Sample and settings

This study was conducted in a sample of 198 individuals who had sought treatment for drinking problems at a tertiary care hospital and seven privately run drug and alcohol rehabilitation centres in the capital Kathmandu and the adjacent Lalitpur district of central Nepal. One centre exclusively served female substance users.

The sample included consecutive admissions in late 2010 that met the following criteria: (1) alcohol was the primary substance of focus, (2) the clients at the time of inclusion did not show features of ongoing intoxication or a complicated withdrawal state and (3) the clients provided written informed consent or a witness was available for confirming the voluntary participation of any illiterate client. Patients with psychotic symptoms were excluded. Abstention in the controlled environment for at least seven days was required for interviewing. Of the 221 clients approached, 210 (95%) agreed to participate. Further attrition was due to ongoing intoxication (two clients), complicated withdrawal (three clients) or presence of psychotic symptoms during initial screening (one client) and incomplete interviews (six clients).

The hospital admitted clients ($N = 30$) usually presented with features of complicated withdrawal and were generally managed with benzodiazepine-based detoxification. The other centres were private rehabilitation centres registered with the national Social Welfare Council and their clients received non-pharmacological facilitation based on the twelve-step groups of Alcoholics Anonymous (AA). Medications were generally discouraged at the rehabilitation centres; some allowed medications prescribed by psychiatrists. A notable feature of both kinds of institutions was that the patients or their family had to pay for treatment; the rates varied across the institutions. The choice of treatment institution depended on the patient's or carer's choice and third-party recommendations.

2.2. Procedure and measures

The ethical review boards at the Regional Committee for Medical Research Ethics of Norway and the National Health Research Council of Nepal approved the study protocol. After obtaining the informed consent, the first author who is a Nepali clinician and trained to administer the questionnaire, conducted interviews in rooms provided by the participating institutions ensuring confidentiality. Questionnaires were in the Nepali language.

Socio-demographic information was captured with the demographic module of the Composite International Diagnostic Interview-version 2.1 (CIDI 2.1) (Robins et al., 1988). Diagnosis of AUD was based on the alcohol module of the CIDI, which is cross-culturally reliable and compatible with the Diagnostic and Statistical Manual of Mental Disorders-IV diagnoses (Wittchen, 1994). Further, alcohol-use pattern, alcohol dependence symptoms and severity features were assessed by using the Alcohol Use Disorder Identification Test (AUDIT) developed by the World Health Organization (Saunders et al., 1993).

Membership of the different typologies, based on taboo or no taboo about alcohol use, was determined by asking the participants to identify themselves into one of the categories. Although this generally corresponded to their caste, the dichotomy was based solely on whether the individual perceived social taboo about alcohol use.

Employment in government or the private-sector with regular earnings was regarded as having a stable job. The minimum salary scale of government employees was used as the low cut-off and the salary scale of first class non-gazetted government officer as the cut-off for high income. Participants were asked if they received adequate moral, logistic and economic support from their significant others when needed. Any illness lasting longer than three months was considered a chronic illness. Participants were asked if any parents had alcohol problems during their lifetimes. Earlier service use was assessed by asking, 'Have you ever been in any kind of treatment for alcohol problems?' Satisfaction with the ongoing treatment was assessed as three categories: satisfied, neither satisfied nor dissatisfied, and dissatisfied.

Despite the possibility of a large variation in the concentration of ethanol in the locally brewed liquors, for reporting purposes one small bar-served glass (roughly 0.2 L) of locally distilled *Rakshi* was considered to be 2 units of alcohol and 1 *mana* (approximately 0.55 L) of fermented product *Jand* was considered equivalent to 3 units, as suggested in the Nepali version of CIDI 2.1.

2.3. Statistical analysis

Analyses were performed using the IBM SPSS Statistics version 19 (SPSS Inc., Chicago, IL, USA). Descriptive data are presented as