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The explanatory models and coping strategies for alcohol use disorders: An exploratory qualitative study from India☆

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ABSTRACT

Purpose: The explanatory models (EM) and coping strategies for mental health problems influence treatment seeking and the subsequent patient journey. The goal of this study was to explore the EMs and coping strategies for alcohol use disorders (AUD).
Methods: We conducted semi structured interviews with 29 men with AUD and 10 significant others (SO) in two sites in India. Thematic analysis was used to analyse data.
Results: The former were predominantly married, literate and employed; the latter were predominantly wives, literate and employed. Alcohol consumption and AUDs are seen to be mainly associated with psychosocial stress, with other factors being peer influences, availability of disposable income and drinking for pleasure. They are perceived to result in a range of adverse impacts on social life, family life, personal health and family finances. Various coping strategies were deployed by men with AUD and their significant others, for example avoidance, substitution, distraction, religious activities, support from AA/friends/family, restricting means to buy alcohol and anger management. Reduction/cessation in drinking, improved family relationships, improved emotional/physical wellbeing and better occupational functioning were the most desired treatment outcomes.
Conclusion: There are considerable similarities, as well as some key differences, observed between the EMs for AUD in India and those reported from other cultures which have implications for the global applicability and contextual adaptations of evidence based interventions for AUD.

1. Introduction

AUDs are second only to depressive disorders as the leading neuropsychiatric cause of the global burden of disease (WHO, 2008). The epidemiological picture in India is characterised by relatively high abstinence rates coupled with high rates of alcohol-attributable mortality and prevalence of AUDs relative to the volume of alcohol consumed per capita (Rehm et al., 2009). Another key epidemiological finding is that the vast majority of persons with AUD in the region are men (Prasad, 2009). Explanatory models (EMs) are described as the 'notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process' (Kleinman, 1980). It is important to take EMs into account in clinical practice as beliefs and behaviours influence help seeking behaviour, acceptability of the treatment, subsequent concordance and eventual patient satisfaction. An accurate understanding of the patients' and significant others' (SO) EMs will enable a clinician to appreciate the patient's response to illness, to develop an empathic relationship and to communicate his explanation and recommendations for treatment more effectively (Sumathipala et al., 2008). The socio-cultural history of alcohol consumption differs significantly across the world (Bennett et al., 1998) and understanding EMs of and coping strategies for AUD are an important step of the clinical process (Callan and Littlewood, 1998). The objective of the exploratory research described in this paper was to describe the EMs of and coping strategies for AUD in India. The key research questions were: what are the causal beliefs for AUD, what is the

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impact of AUD, what are the coping strategies for AUD, and what are the desired outcomes of interventions for AUD. Ultimately, we aimed to use these findings to inform the development of contextually appropriate psychological treatments for AUD.

2. Methods

2.1. Setting and sample

The study was carried out in AUD treatment settings and primary care clinics in the states of Goa and Maharashtra, India. Maximum variation sampling was used to obtain broad coverage of persons accessing a range of available treatments for AUD. Participants were men with AUD and significant others (SO), who were defined as someone who was living with person having AUD and playing an active role in his care. The diagnosis of AUD was made by a trained healthcare provider, viz. psychiatrists or de-addiction counsellors.

2.2. Data collection

Data collection was done through semi structured interviews, carried out by trained research workers. All participants were interviewed face to face either at their homes or at the care provider's premises. Interviews with patients and SOs were carried out separately. All interview sessions were audio recorded and the research workers also made field-notes about the content of the interview and non-verbal behaviour. The semi-structured interview guides were developed in English and translated into the local languages (Konkani and Marathi). The questions in the interview guide explored issues such as the participant's perceptions of what had caused their problems, how these had affected their lives, how they coped with it and what outcomes they desired from treatment. Interim analyses of the initial interview data were used to refine the guide themes and probes. Data collection was stopped once a point of data saturation was reached and no new themes emerged.

2.3. Analysis

Data from the semi structured interviews were entered into and coded in Nvivo 8. The analysis was a combination of deductive and subsequently inductive (through thematic analyses) strategies. Initially, a set of pre-determined codes, namely 'causal beliefs', 'perceived impact' and 'desired outcomes' were developed based on some of Kleinman's Eight Questions, a well established theory of explanatory models (Kleinman et al., 1978), and were deductively applied to the data. Subsequent analysis involved inductive generation of new codes from raw data (e.g. 'coping strategies'). These codes were used to generate a new coding template, which was then applied to the remaining interviews. Codes were then compared with each other for similarity in meaning. Similar codes were collapsed into inclusive categories and clusters of related codes were organised under other codes, forming hierarchies. Themes were derived by retrieving pieces of data pertaining to codes and by examining their meaning in relation to the research questions. Patterns were derived by eliciting similarities and differences between themes generated from interviews of men with AUD and SOs to get a better understanding of where they converged or diverged. In the final stage, simple frequencies were tallied for all the major themes that were derived (Neuendorf, 2002, Chapter 3).

2.4. Ethical issues

The Institutional Review Boards at the London School of Hygiene and Tropical Medicine and Sangath reviewed and approved the proposal. The study was also approved by the Indian Council for Medical Research. Written informed consent was taken individually from all participants.

3. Results

Semi structured interviews were conducted with 29 men having AUD and 10 significant others (SO). Of the 29 men with AUD, 22 (75.9%) had alcohol dependence and the rest had non-dependent AUD. This pattern is representative of men who receive an AUD diagnosis in these settings. The mean age of the men with AUD was 42.8 years (range 25–65 years). 27 (93.1%) were married. All participants were literate with either primary ($n = 4$; 13.8%), secondary ($n = 16$; 55.2%) or college/university education ($n = 9$; 31%). The majority were employed ($n = 24$; 82.8%). They were referred by AA members ($n = 6$; 20.7%), residential de-addiction centre ($n = 4$; 13.8%), psychiatrists ($n = 11$; 37.9%), non formal care providers ($n = 5$; 17.2%) and GPs ($n = 3$; 10.3%). A large proportion of the family SO's was female (90%), married (90%), educated to secondary level and above (70%) and employed (70%). Their mean age was 38.8 years (range 28–62 years) and all except one were spouses of persons with AUD.

3.1. Causal beliefs

Four broad themes emerged as causal attributions for alcohol use: psychosocial causes, peer influences, availability of disposable income and drinking for pleasure.

3.1.1. Psychosocial stresses

The semi structured interviews confirmed the perceived role of psychological stressors, attributed primarily to financial problems and family disturbances, leading to AUD. 9 (31%) of the men with AUD and all SOs ($n = 10$, 100%) reported a psychosocial stressor as contributing to the onset of the AUD. The impact of financial loss in a business venture was described thus: "*So I had to wind up that business also. . .It was more out of frustration that I took to drink*" (M, 36). Problems in the family environment were also identified by those with AUD and SO's as a major factor leading to drinking problems. One participant attributed his drinking to the stress caused by his wife's extramarital affair. "*I came to know* [about wife's extra marital affair]. *From that time my mind was upset and I did not know that alcohol is a disease, which it is like a sickness. I thought you just drink it and then forget about it. But it gives only temporary relief*" (M, 45).

3.1.2. Peer influences

Peer pressure was reported as one of the key reasons for sustained alcohol use or dependence by a third of the men with AUD ($n = 9$, 31%) and SOs ($n = 3$, 30%). Participants described their drinking starting in social situations and acknowledged the role of peer influences on both drinking and the evolution of drinking problems. A farmer described a routine of drinking after work as follows, "*After farming work is over, things like alcohol-meat* [consumption] *begin. In this, even if we are not willing, we have to participate on the insistence of others*" (M, 40). SO's also acknowledged the role of peer influences in the development of AUD. A wife describing her husband's drinking said, "*Yes, I asked him* [husband]. . .*Why do you drink? Is there any tension related to wife or children? Why? And he told me, 'No I drink with my friends circle*' (F, 30, Spouse).

3.1.3. Availability of disposable income

Alcohol consumption is often seen as a symbol of economic status and availability of disposable income was perceived as leading to drinking and AUD by a minority of men with AUD ($n = 3$,