

ORIGINAL ARTICLE

Help seeking behavior in patients with alcohol dependence in a tertiary care hospital in eastern Nepal

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Abstract

Introduction: Though alcohol problem is common in Nepal, fewer patients seek help. Current study aims to see help seeking behavior among alcohol dependence syndrome (ADS) cases admitted in psychiatry ward of B P Koirala Institute of health sciences, Dharan, Nepal.

Method: All ADS cases admitted in the psychiatry ward in 12 month period (2004/5) were enrolled. It is a descriptive study using the 'International classification diseases and infermities' (ICD)- 10th edition as a diagnostic tool and semi-structured proforma to collect information about clinicodemography and help seeking.

Results: Out of total 51, 82% were male. Only 3 cases came solely to quit drinking. Common presentations at admission were behavioral problems (39.2%), restlessness (37.3%) and disturbed sleep (27.5%). Most were brought by family members (43%); some referred by other departments and some others by paramedical, rehabilitation centres and traditional healers. Thirty five cases (68.6%) did not consider drinking as a problem. Thirteen percents were receiving treatments from other places. Poverty and conservative attitude in 10% each were other reasons for treatment delay. Before reaching this service, 96% had used some home remedies, 23.5% visited traditional healers and 12% local drug stores. Fifty nine percents had received services from 2 or less other places before reaching the psychiatrist for recent problem whereas 41% had 3 or more.

Conclusion: The main reason for delay in help seeking for ADS in Nepal is the lack of realization that drinking and its consequences are at all any problem.

Key words: alcohol, alcohol dependence, BPKIHS, help seeking, psychiatric in-patients

INTRODUCTION

Alcohol dependence syndrome (ADS) is common in community¹⁻³, more so in eastern part of Nepal.⁴⁻⁵ ADS cases usually do not visit psychiatric service.⁶ When they present to psychiatric service, they usually have higher rates of both physical⁷ and psychiatric comorbidities⁸ and they are likely to present as psychiatric emergencies.⁹ Despite of a great magnitude and burden of the problem, there is a scarcity of data about help seeking in ADS from this part of Nepal.

Current study was carried out in the period of 12 months (July, 2004 – June, 2005) in the department of Psychiatry, B P Koirala Institute of health sciences (BPKIHS), Dharan, Nepal to explore into help seeking behavior among ADS cases by the time of psychiatry ward admission. Overarching objective would be to identify the barriers of help seeking process and strategies to overcome them.

METHODS

It is a descriptive cross sectional study in consecutive inpatients with ADS diagnosed according to the ICD-10 criteria.¹⁰ It was carried out among all 51 consecutive consenting cases of ADS admitted in psychiatry ward of

BPKIHS, Dharan, Nepal within 12 month period of data collection from July, 2004 to June, 2005.

The study was approved by the institute ethical review board. Informed written consent was collected from the subjects. Strict confidentiality of information was maintained. The information was utilized for the appropriate management of the cases concerned and similar cases in general, and for the research.

All patients with significant medical complications making them unable to be interviewed were excluded from this study.

Information on different aspects of help seeking behavior and relevant demographic and clinical profiles were collected using the semi structured proforma which was designed and approved by the department. The proforma consisted of and in all cases, an endeavor was made to investigate into and record:

1. The possibly relevant factors (demographic- age, gender, education, marital status; geographical/ social-residential setting, accessibility to the hospital),

2. Clinical variables (presenting complaints, referral sources),
3. Subject's/ responder's view about 'reasons for treatment delay, and
4. Pathway to current service.

Data were entered into a computer and analyzed using the 'Statistical Package for Social Science' (SPSS) - software.

RESULTS

Out of total of 51 cases, nine (18%) were female and 42 (82%) male (see table 1). The maximum numbers of cases were in the age group of 30-40 (43%) and 40-50 years (33%). The mean age of the patients was 39.65 years (Minimum 25, maximum 65, Standard deviation 8.68). A great majority of the cases 45 (88%) were married and some were separated 3 (5.9%). Most of the cases were either from joint family 23(45%) or nuclear 22 (43%), and others extended 7.8% and broken 4%.

** Multiple response categories- One respondent may have one or more responses.*

Table 1: Socio-demographic profiles I: Gender, Age, Marital status and family type.

Gender	No. of cases (%)
Male	42 (82)
Female	9 (18)
Age group (years)	
< 30	4 (7.8)
30-39	22 (43.1)
40-49	17 (33.4)
50-60	6 (11.8)
> 60	2 (3.9)
Marital status	
Married	45 (88.22)
Single	2 (3.9)
Separated	3 (5.9)
Widow	1 (2.0)
Family type	
Nuclear	22 (43.1)
Joint	23 (45.1)
Extended	4 (7.8)
Broken	2 (4.0)

As per table 2 Common castes among the help seekers were: Rai, the most 15 (29%), Brahmin, Chhetri, Limbu, Tamang, Newar, and Magar. About 80% were traditional users.

Among them, Hindus (including Kirantis) were 78% and Buddhists 16%. About 84% were educated to different levels and only 16% illiterate.

Majority (78%) were employed in different professions and 22% currently unemployed. Two thirds of the cases 34 (66.7%) were of middle socio-economic status.

Table 2: Socio-demographic profiles-II: Caste/ ethnicity, Religion, Education, Occupation and socio-economic status

Caste	No. of cases (%)
Rai	15 (29.4)
Brahmin	10 (19.6)
Chhetri	8 (15.7)
Limbu	5 (9.8)
Newar	4 (7.8)
Tamang	4 (7.8)
Magar	1 (2.0)
Others	4 (7.8)
Religion	
Hindu	40 (78.4)
Buddhist	8 (15.7)
Muslim	1 (2.0)
Christian	1 (2.0)
Others	1 (2.0)
Educational status	
Illiterate	8 (15.7)
Grade I-III	4 (7.8)
Grade IV-VII	13 (25.5)
Grade VIII- SLC	15 (29.5)
Intermediate	5 (9.8)
Graduate	3 (5.9)
Higher	3 (5.9)
Occupation	
Business	7 (13.7)
Agriculture	6 (11.8)
Labor	1 (2.0)
Service	9 (17.6)
House making	4 (7.8)
Teaching	3 (5.9)
Unemployed	11 (21.6)
Others	10 (19.6)
Socio-economic status	
Lower	13 (25.5)
Middle	34 (66.7)
Upper	4 (7.8)

Almost half were from urban and rural settings each as per the data in table 3. Nearly half of the cases were from the readily accessible places, 29.4% from far but accessible and 23.5% from the places with no facility of transportation.

Table 3: Residential setting and accessibility to the hospital

Residential setting	No. of cases (%)
Rural	25 (49)
Urban/Dharan	26 (51)
Accessibility to the hospital	
Readily accessible	24 (47.1)
Accessible	15 (29.4)
Far	12 (23.5)

Figure1: Presenting complaints

Only one third of the cases realized drinking as a problem. Among common presentations at the time of admission were: behavioral problems (39.2%), restlessness (37.3%)

and 27.5% disturbed sleep.

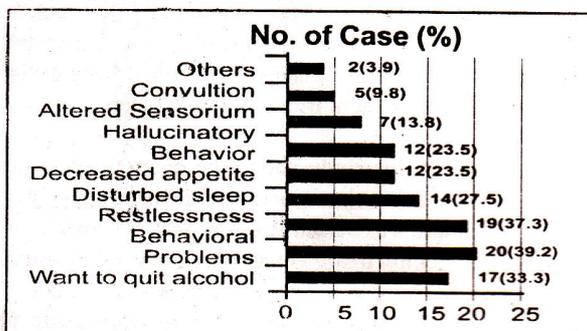


Table 4: Sources of Referral

Source of referral	Frequency (%)
Self	6 (11.8)
Family members	22 (43.1)
Relatives/ neighbors	9 (17.6)
Alternative/ traditional	2 (3.9)
Paramedics	2 (3.9)
Other doctors	8 (15.7)
Rehab. Center	1 (2.0)
Others	1 (2.0)

As mentioned above only 12% came themselves. Most cases (43.1%) were brought by family members or (17.6%) by relatives or neighbors and 15.7% referred by other doctors/ specialists.

Table 5: Reasons of delay in treatment

Reasons	No. of case (%)
Not took as problem	35 (68.6)
Not knew about treatment	9 (17.6)
Treating elsewhere	7 (13.7)
Conservative attitude	5 (9.8)
Lack of money/ poverty	5 (9.8)
Distance from hospital	1 (2.0)
Others	1 (2.0)

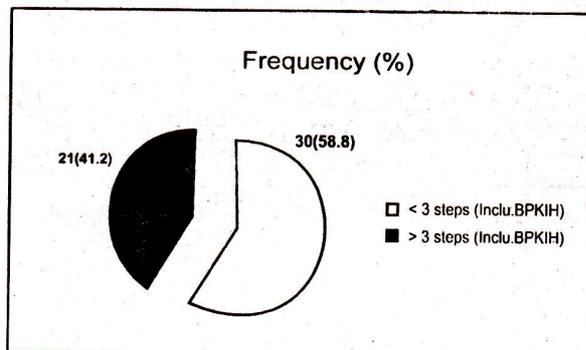
Many of the patients (68.6%) did not take it as a problem, 17.6% did not know about the treatment facility and 9.8% cases did not come because of poverty and conservative attitude each.

Table 6: Treatment strategies used before reaching the current service

Category level	No. of cases (%)
Home remedy	49 (96.1)
Traditional, e.g. Dhama	12 (23.5)
Medical stores	12 (23.5)
Ayurved/ homeo	2 (3.9)
PHC/ nursing home	8 (15.7)
Secondary/ rehab. centre	6 (11.8)
Other tertiary center	4 (7.8)

Most people had adopted one or other method before- 96% some home remedy, 23.5% visited traditional healers and medical stores each, 15.7% PHC or nursing home, 11.8% secondary treatment centre or rehabilitation centre.

Figure 2: Number of other help seeking steps of pathway in reaching to BPKIHS



Nearly 60% of the individuals had presented to BPKIHS in third or less than third step of help seeking pathway for recent health problem related to alcohol use.

DISCUSSION

In context of Nepal, drinking is socially acceptable in most of the sub-cultures. People are poor, less educated and do not always have access to proper health facilities. Although there have been few studies on this regard, it is evident that there are many barriers preventing problem drinkers from reaching the health care facility, like BPKIHS. Alcohol problems are much more widely spread in the community than are presented clinically.^{6,11} People with alcohol dependence do not perceive themselves as disabled and do not seek help. It would be beneficial to address this population so that more of them will seek help.

Most of the research done on the process of help seeking among problem drinkers so far have focused on characteristics of persons with an alcohol problem and the factors affecting their help seeking behavior^{12,13,14} as well as the triggers and barriers to treatment entry.^{15,16}

In this study, we tried to see the individual/ personal characteristics of study subjects especially sex, educational status, place of domiciles and residential settings, marital status and socio-economic status. We categorized the subjects into two groups only, because of small sample size. First group consists of those (58.8%) presenting to this tertiary care hospital after visiting two or less than two other healing systems or help seeking steps. Second one consists of those (41.2%) presenting after consulting three or more other treatment systems. Assuming that the first one represents earlier treatment entry than the later, we did not find any statistically significant difference in different socio-demographic variables: sexes, educational levels, the place of domiciles and settings, marital status and socio-economic status. Our study was carried out in the subjects from inpatients who presented mainly because of some other serious problems. There was no modern treatment alternative for those individuals in that situations

but to attend the nearest possible treatment facility. Perhaps because of these factors, we did not get any statistically significant difference in above mentioned socio-demographic variables from the perspective of help seeking.

While presenting to the service of this department, only 3 cases came with the sole purpose of quitting drinking. Many had one or other, medical/ physical⁷ or psychiatric co-morbidities.⁸ Many individuals had problems with interpersonal relationship and some legal problems. At the time of presentations, they had different complains: behavioral problems (about 40%), restlessness (37%), sleep disturbance (28%), anorexia (24%), hallucinatory behavior (24%), altered sensorium (14%), seizures (10%) and others (4%). This pattern of reporting problem at presentation (rather than problem drinking itself) is consistent with the earlier findings of Proudfoot et al, 2002.¹⁷ Only one third of the cases wanted to quite alcohol for their problem at presentation even though those added problems were related to alcohol consumption.

Most of the cases in this study i.e. nearly 70% did not perceive themselves as having problem before developing some complications. They did not consider habitual drinking as a problem and nor did they seek help. Only 6 (11%) cases had come themselves. Nearly half were brought by family members and 18% by relatives. As this is a general hospital, many of the individuals (16%) had already been seen by other specialists/ doctors before referring them to psychiatric service, similar finding was also observed in earlier study about psychiatry referral.¹⁸ One case was referred by a staff of rehabilitation center and other one by authority agency, i.e. police department. Hingson et al's study in 1982 on problem drinkers reported that they were generally referred by friends and relatives to different services.¹⁴ In our study, along with friends and relatives, vast majority of cases were brought to service by family members themselves because of some serious complications. We have less people referred from alcoholic anonymous or rehabilitation centers (2% only) than Hingson et al had (29% and 33% respectively) which is probably due to lack of these networks in this region.

In this study, we tried to ascertain the *help seeking pathway* before reaching to this hospital. Thirty cases (59%) had sought service from one or two healing settings for the presenting problem. About 41% had utilized service of three or more of other services. This number is more than the finding of Hingson et al 1982 (33% utilizing multiple helps).¹⁴ Forty nine cases (96%) had used one or other forms of home remedy, e.g. herbal, ritualistic measures. Twelve patients (23.5%) had visited traditional healing systems like Dhami, Jhankris and only 2 cases homeopathy or Ayurveda. Only less proportion of cases visiting these laternative healers may be because of the fact that they were mostly from the areas around the hospital and by that time they had already developed some serious complications.⁹

Eighteen percent cases reported that they were *not aware* of the treatment facility, 10% had negative attitude towards modern measures for this problem and preferred other alternative methods, and 10% had difficulty with affordability and some other cited the distance as barrier to seeking help from this tertiary care hospital. Four cases (14%) had been referred or from other tertiary care centers. Most of them were from around the hospital area but working in other towns/ places.¹⁹ So, it had been easier for them to get treatment from their own place.

The findings of this study should be entertained in the light of some inherent limitations, i.e. 1. Sample size was small, 2. Sample was biased in a way that it studied only the patients seeking treatment at a tertiary level hospital. Therefore, the sample might not represent the general population and the results may not be applicable to community. Hence, further community based studies are recommended for more information.

CONCLUSION

Many of problem drinkers do not seek help. They present to psychiatric service late when they have complications. The main reason for delay in seeking help for ADS is lack of realization that drinking and its consequences are at all any problem. Hence, public awareness regarding ADS should be raised in different levels through various sound programs

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