CHAPTER V

DISCUSSION CONCLUSION AND SUGGESTION

DISCUSSION

PART 1 From table 4.7-4.14, The results on prevalence of alcohol use disorders and their epidemiologic data. We found that alcohol drinking is quite high in the community of Nakhon Sawan Province (79.1 percent). Among 38.8 percents diagnosed by Hasin's questionaires as alcohol use disorders are alcohol dependence 16.6 percents and alcohol abuse 14.2 percents. Compare to some papers that have been studied on prevalence of alcoholism found the numbers of prevalence were 25 and 32 percents (Tanchaiswad W., 1990) and (Otrakul A. et al, 1988). The differences in prevalence were due to studied population and diagnostic tests. They used MAST (Michigan Alcoholism Screening Test) that classified only alcohol dependence. MAST is not up to date because DSM-III-R (Diganostic and Statistical Manual of Mental Disease, edition III-revised) classified alcohol use disorders into alcohol dependence and alcohol abuse. Those studies surveyed in out-patients clinic in general hospitals so the prevalence should be high.

The demographic distribution among alcohol use disorders, the results showed more male than female, common in age range 25-54, most were married, agriculturists, low education, low income and had familial history of alcohol drinking. These data parallel well the same with one study except for occupation (Vajarajote P. et al, 1985). The difference in occupation may reflected study setting which is governmental hospital in Bangkok and they surveyed among alcoholics admitted in the hospital so they found high distribution of governmental officers and employee.

PART 2 From table 4.15-4.28, Data analyses on drinking behavior, pattern of drinking, behavioral cosequences, co-morbid mental problems, general well-being and personality profile among alcohol use disorders.

Age onset of drinking (Table 4.15), about 65 percents of alcohol use disorders started their drinking at the age between 15-24 year. This is the interesting data for selection of target groups in planning of preventive strategies.

The reasons that they started their drinking were social activities and persuation by friends. Educational program is necesssary to create a new value in the new

generations and a treatment program by using peer assessment or self help group should be considered.

Freguency of alcohol drinking among alcohol use disorders (Table 4.17), type of alcohol beverages used (Table 4.18) and amount of alcohol used (Table 4.19) should be considered to set a research to find optimum quantity of alcohol drinking that do not make harmful to the drinkers.

From table 4.22 and 4.33, alcohol use disorders especially in alcohol dependence group used alcohol to releive mental stress but they dit not request for help or ask for treatment. Creation new attitude and mental health promotion should be strengthened. Most of alcohol use disorders were poly-drug used (Table 4.24) so the policies and strategies in prevention and control of drug abuse are advocated.

Data analysis on behavioral consequences of alcohol use disorders indicated a lot of problems associated with alcohol drinking such as health problems, accidents, familial problems, violent behavior, social, work, and financial problems. A compaign should be launched to alliviate these consequences.

For general well-being total score, we found that most of alcohol use disorders were under the categories of moderate to severe distress. So preventive and control program should be combined or go along with mental health promotion and prevention programs.

According to personality profile by using 16 PF questionaires (Table 4.28), no definite or clear deviation of the curve score in each personality profile. The postulated reasons for their finding are : 1) was detected the technical problems of the instrument which is too long and difficult for people in the community with low education 2) the population represented in the survey were homogeneous so personality profile were not specific among alcohol use disorders.

For statistical analysis between two groups of alcohol use disorders we found no differences because both groups were alcohol use disorders or because of number of cases are too small (68 and 58 for alcohol dependence and alcohol abuse).

PART 3 Data analysis on factors associated with alcohol use disorders. We devided the population into 3 groups : no drinking, alcohol drinking without disorders and alcohol use disorders and then we analyse and calculate to test differences by the effect of no drinking, and

drinking and we also test between 2 groups of alcohol drinking without disorders and alcohol use disorders too.

We found demographic factors associate with alcohol use disorders were age (F-test = .0002, $P < .05$), sex ($\chi^2 = 50.6$, $P < .001$), marital status ($\chi^2 = 26.9$, $P < .001$), occupation ($\chi^2 = 31.2$, $P < .001$), education ($\chi^2 = 42.19$, $P < .001$), familial history of alcohol drinking ($\chi^2 = 24.29$, $P < .001$). These informations will be useful for defining risk groups or protective factors in prevention and control programs.

For behavioral consequences (Table 4.40-4.55), we found a lot of problems associate with alcohol drinking and alcohol use disorders. All of these problems, some bring social harm, some are causes of death and some bring physical and psychological distress and illness. It should be considered to alleviate these problems quickly.

For general well-being, total scores and subscores labels (Table 4.56-4.60) we found that alcohol use disorders were different significantly from others. Their quality of life are not good. It should be managed by combining with mental health promotion and prevention programs.

For personality profile (Table 4.61), among 16 profile we found only profile that alcohol use disorders were significant different from no drinking group. That was trust and suspiciousness profile. Alcohol use disorders score deviate to the pole of suspiciousness but we cannot consider that it is a baseline personality that is a cause or it is an effect after drinking make the score deviation.

CONCLUSION

The prevalence of alcohol use disorders in the community of Nakronsawan Province was 30.8 persents. We diagnosed as alcohol dependence 16.6 percents and alcohol abuse 14.2 percents. Alcohol drinking among population in the community of Nakhon Sawan Province was 71.9 percents.

We found that men drink alcohol more than women. Most alcohol use disorders were found in the age group between 25-54 year. Most of them were married. Their occupations were agriculturists. They finished primary alcohol, low income (less than 3,000 Baht per month) and had family history of alcohol drinking.

About drinking behavior, pattern of drinking, co-morbid mental problems and general well-being, personality profile and behavioral consequences among alcohol use disorders we found that :

Age of onset of drinking was commonly found between 15-24 year about 65 percents.

Reasons for starting alcohol use were social activities and persuation from friends.

Frequency of alcohol drinking was one time or more per week.

Most of alcohol use disorders prefered to drink "arrack" and mix with herbal medicine.

The amount of alcohol use about 1-3 glasses per time.

Most of alcohol use disorders perfered to drink in the evening, took 1-2 hour for drinking, inside and outside home, with friends.

Most of them had feeling or emotional changes before and after drinking such as : could not control awareness, easy irritable, decrease apetite before drinking.

The changes after drinking were hanging, intoxication, hot sensation in stomach, talkative, louder noise, increase apetite, impulsive, itching, headache, dizziness, palpitation, hypomotor retardation and better sleep.

Most of alcohol dependence used alcohol as a tool for mental stress relief more than alcohol abuse ($p < .005$).

Most of alcohol use disorders thought that alcohol cessation or reducing was not difficult but they did not want to stop. Small numbers of them requested for help. Most of them could stop only 1-3 month and then drink again for the same reasons of starting.

Most of alcohol use disorders had used other drugs and substances and were still on using them such as cigarrettes, analgesics etc. Most of them were poly-drug used (42 percents).

We found a lot of behavioral consequences among alcohol use disorders such as health problems, accidents, fighting, familial problems and conflicts etc.

Most of alcohol use disorders had moderate to severe distress by GWB scale measuring.

We found that personality profile were not specific to alcohol use disorders.

For factors associated with alcohol drinking and alcohol use disorders the results show that :

Sex, age, marrital status, occupation, education level, familiat history of drinking, reasons of starting alcohol are, emotional changes before and after drinking, use alcohol or a tool for stress relief, requested for help from others or physician were significant association with alcohol use disorders and alcohol dependence.

For behavioral consequences we found that hospital treatment, treatment in Mental Hospital, health problems, brain and C.N.S. problems, liver problems, stomach problems, accidents, catched by the police, fighting, injuries by others, injuries to others familial problems, social problems, financial problems, working problems and sexual problems were associated with alcohol drinking especially with alcohol use disorders. ($P < .05$)

For general well-being total score we found that alcohol use disorders were significant different from other groups at $P < .05$. The alcohol use disorders had high percentage in moderate to severe distress.

By analysing subscore labels of GWB we found that for the subgroup of anxiety, depression and positive well-being were significant differences among no drinking, alcohol drinking and alcohol use disorders. For other subscores : self-control, vitality and general health were not significant different among 3 groups.

For personality profile there was only L-profile (Trust-suspiciousness) that 3 groups had significant different at $P < .05$ by deviation to more suspiciousness in alcohol dependence group.

SUGGESTION

We have conducted a community survey as a pilot study. We have developed an instrument used for conducting the survey and find a lot of informations from alcohol drinking and alcohol use disorders. If we modified some questionaires from this study, it will be used as a frame for conducting a national survey. If we have an adequate data from the national survey, we can develop a national policy to minimize the harm associated with alcohol use while interfering as little as possible with the freedom of individuals to exercise personal responsibility for the use or non-use of alcohol beverages.

Because there is no universally safe level of drinking and because most alcohol related problems occur in persons who would be regarded by most Thai as habitual drinkers, it is difficult to direct all efforts at reducing alcohol related problems to those whose drinking is habitually irresponsible. Accordingly, although a targeted approach is appropriate in some instances with specific or appropriate strategies, relating either to habitual heavy drinkers or to specific problems such as accidents, in general efforts to minimize alcohol related problems need to be broadly based. However no single initiative itself is likely to effect the significant improvement sought. This study has shown the baseline informations for further study on strategic planning in prevention and control alcohol use disorders. Which policies among educational policies, control policies, legal policies, treatment policies, community mobilization policies will be useful, it should be proposed another study to find out.