

**ALCOHOLISM AMONG OUTPATIENTS WITH
PSYCHIATRIC MORBIDITY
(A Kenyan study)**

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ABSTRACT

Out of 881 randomly selected outpatients in four rural district hospitals in Kenya who underwent a two stage screening procedure for a psychiatric disorder, 24.9 percent had psychiatric morbidity. Further analysis showed that 12.7 percent of them had an alcohol related disorder as defined by ICD-9 (WHO, 1978) under the categories 291 and 303. For the screening of alcoholic cases brief MAST was used. The author found this instrument a quick method for identifying potential alcoholics.

At present, such cases go undetected and untreated. Some important issues related to alcohol drinking in rural Kenya are discussed. Most of our patients drank the locally brewed alcoholic beverages of variable ethanol contents. The health planners and primary health workers (PHW) will have to pay more attention to the widely prevalent alcohol abuse which seems to masquerade in various forms of physical, social or psychological problems. Indeed, more intensive training of the PHWs in detecting and advising alcoholics may be the best method in the rural setting.

Key words : Alcoholism, outpatients, psychiatric morbidity, Kenya

Kenyan studies have now established that use and abuse of alcohol is widespread in various strata of our society. For example, Dhadphale et al. (1982a) have estimated that 17% of school children were consuming alcoholic drinks at least once a week.

Similarly, in a community survey, Otieno et al. (1979) found that 30% or more of rural villagers were drinking excessive quantities of alcohol. Thus, it may be assumed with a fair amount of certainty, that alcohol use and abuse has reached such an alarming degree that we should contemplate effective measures to discourage excessive drinking and identify the affected and vulnerable segments of our

society. On the international scene, WHO experts have been busy formulating a policy to try to help the developing nations to identify alcohol related problems. During the last ten years, the Royal College of Psychiatrists "alcohol our favourite drug" (1986) and British Medical Journal's "ABC of alcohol" (1988) have covered almost all relevant aspects of alcohol use in the community. The information contained in these publications is vital to research on alcoholism.

Very little is known about the exact magnitude of alcohol related psychiatric morbidity in Kenya. The present study was undertaken to provide such data. The author

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and his team selected four district hospitals for this project, they were; Kisii, Kisumu, Meru & Voi.

The major aim of this inquiry was to estimate the frequency of alcoholic psychosis (ICD 291) and alcoholism (ICD 303) satisfying the ICD-9 (WHO, 1978) criteria, among the hospital outpatients who had psychiatric morbidity.

MATERIAL AND METHOD

All outpatients with an identifiable psychiatric disorder or psychiatric morbidity were administered the Michigan Alcohol Screening Test 1971, brief version (Porkony et al., 1972) (MAST). A question related to attendance at an alcoholics anonymous (A.A.) was deleted as it was irrelevant in rural Kenya. For the screening of psychiatric morbidity (PM) the following instruments were employed (a) the SRQ (Self Rating Questionnaire, Herding et al., 1980) which was a locally validated version of known sensitivity and specificity for first stage screening and (b) the SPI (Standardized Psychiatric Interview, Goldberg et al., 1970) for the second stage of the screening procedure to confirm the cases as identified by stage one of screening. ICD-9 criteria were used for diagnoses of alcohol related problems. The details of the screening procedure is described by Dhadphale et al. (1982b).

Before administering the SRQ, SPI and brief MAST, all relevant demographic data were collected and patient's agreement to participate in the project was sought.

RESULTS

For the purpose of this study, any psychiatric patient scoring 5 points or more on the brief MAST was considered as an 'alcoholic case' (AC). Those scoring less than 5 points were non cases (NC).

TABLE 1
DISTRIBUTION OF PSYCHIATRIC MORBIDITY
AND ALCOHOLISM IN A SAMPLE OF OUTPATIENTS

Category	No.	Percentage
Total out patient's screened	881	100
Confirmed psychiatric morbidity	220	24.9
Alcoholics	28	3.1% to total 12.7% of psychiatric patients

TABLE 2
PATIENTS WITH PSYCHIATRIC MORBIDITY
(N=220)

Age (in years)	Alcoholics	Non-alcoholics
18-25	13	83
26-35	4	42
36-55	11	67
Total	28	192

$X^2 = 0.2057$, $df=2$, $p=NS$

TABLE 3
SEX DISTRIBUTION

Sex	Alcoholics	Non-alcoholics
Male	21	91
Female	7	101
Total	28	192

$X^2 = 7.4505$, $df=1$, $p<0.02$

DISCUSSION

Patients included in this inquiry had come to outpatient clinic for various bodily complaints. Most of them had physical ailments and were not seeking treatment for their alcohol related problems. Actually they were not even aware that their somatic symptoms could have been due to consumption of alcoholic beverages.

Similarly, psychiatric cases were also ignorant of their mental condition. The position of clinical staff managing such over crowded outpatient clinics is precarious as they neither have time nor facilities to apply a screening test such as MAST to identify the alcoholics, due to an overwhelming volume of physically ill patients.

Although 3.1 per cent of clinic population had a diagnosis of 'alcoholic case', it is widely believed that for each detected alcoholic there is at least one undetected. Moreover, we screened only psychiatric patients. In outpatient clinics it is just not possible, for practical reasons, to administer the brief MAST to a sample unless it has undergone first-stage screening. The present exercise provided much useful data.

Male predominance among AC is an important feature in this sample, male to female ratio was 3:1. Further, all alcoholic psychosis cases, (ICD 291) were older males showing that drinking appears to be a male prerogative of elderly men. Similar results have been found in India. (Ray & Chandrasekhar, 1982). At least in rural Kenya women do not seem to drink as much as the men do.

Almost all AC cases were drinking a mixture of beer, *chang'aa*, *muratina* or assorted local brews of a high alcohol content. There were no whisky, gin or vodka drinkers which reflects the rural scene and economic status of the sample. Both young and old Kenyans were drinking excessively which shows a dangerous trend, pointing to a relatively earlier age of onset of alcohol related disorders.

In the absence of sensitive liver function tests (such as gamma GT), a thorough neurological assessment, due to constraints such as lack of space or laboratory facilities to undertake such investigation, imposes severe limitations on expressing results more clearly. For example, we were unable to precisely assess the physical sequelae of excessive alcohol consumption; such vital information is needed for more effective treatment of alcoholics.

This work however confirms that there is a substantial morbidity related to drinking in our outpatient clinics. Sadly, at present these drinkers are missed as seriously ill patients and receive treatment only for their presenting complaints, while they continue to drink until more serious complications bring them back to the clinics and even then they get treated for their presenting complaints as the clinic doctor rarely has time to inquire about a patient's drinking habits.

It can be concluded that brief MAST may provide an easy screening instrument to identify alcoholics. We need to establish facilities to treat AC in rural areas. Other social and educational measures as well as aggressive policy directed towards the primary prevention and coordinating research projects needs to be formulated by a national body such as the National Commission on Alcoholism and Drug Abuse.

In bigger towns, general practitioners treat those patients with known alcoholic problems who can afford to pay medical bills. More often the GPs miss alcoholics and it may be an interesting research to conduct a similar study among urban GP's patients for comparison.

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APPENDIX

Brief Mast

1. Do you feel you are a normal drinker ?
YES/ NO (2 points)
2. Do friends or relatives think you are a normal drinker ?
YES/ NO (2 points)
3. Have you ever lost friends or girlfriends or boyfriends because of drinking ?
YES /NO (2 points)
4. Have you ever got into trouble at work because of drinking ?
YES/ NO (2 points)
5. Have you ever neglected you obligations, your family, or your work for two or more days in a row because you were drinking ?
YES /NO (2 points)
6. Have you had delirium tremens (DTs), severe shaking, heard voices or seen things that were not there after heavy drinking ?
YES /NO (5 points)
7. Have you ever gone to anyone for help about your drinking ?
YES /NO (5 points)
8. Have you ever been in a hospital because of drinking ?
YES /NO (5 points)
9. Have you ever been arrested for drunken driving or driving after drinking ?
YES /NO (5 points)
(Question on attendance of AA meetings was omitted) >5 points = 'case'

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