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# ALCOHOL USE AMONG TRIBALS AND NON-TRIBALS OF RAJASTHAN: A COMPARATIVE STUDY

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Background: This research aims to explore the factors that lead to alcohol consumption as well as the perspectives on addiction and its impact on dependency levels among people from different ethnic backgrounds. Cultural acceptance of alcohol can shape individuals' attitudes and understanding of the substance, which can consequently influence their susceptibility to addiction.

Materials and Methods: A cross-sectional design was used for the investigation, which was carried out at a mental health facility. Twenty patients from the state of Udaipur from both tribal and non-tribal communities made up the research population. The ICD 11 diagnostic criteria for mental and behavioral problems caused by the alcohol dependent syndrome, with active dependence, were met by the patients; those with concomitant conditions or consequences were not included. A newly created Sociodemographic Clinical Performa, a modified Reasons for Substance Use scale, an Addiction Belief scale, and an Alcohol Dependence scale were used to evaluate the subjects.

Statistical Analysis and Results: A disproportionately large proportion of tribal members stated drinking alcohol for social enhancement and coping with unpleasant emotions rather than for personal enhancement. For individuals who used alcohol as a coping mechanism for unpleasant feelings, addiction was severe. Across all cultures, it was shown that there was a stronger belief in the free-will paradigm, with no relationship to the purpose of intake. It is difficult to extend this cross-sectional study design, which was based on patients, to the general public. Conclusion: The main cause of the higher prevalence of substance dependence in tribal appears to be societal acceptance and pressure, together with severe emotional difficulties. The demands of the ethnic groups should be considered when planning primary prevention.

Key words: Alcohol dependence, culture, free-will, tribes

One of the most important amenities in every society is good health. To develop a stronger health system, the requirements of society must be recognized and met. One of the state's top areas of public health concern has been highlighted as alcohol misuse.[1] Despite identical drinking rates, developing nations like India have more issues with alcohol abuse than developed nations.[2] The explanations cited in the research include the prevalence of nutritional and infectious disorders, social and economic hardship, an environment that is risky and accident-prone, and a lack of established procedures.

The issues associated to alcohol are essential given the increased prevalence of alcohol consumption in tribal[1], as well as the prevalent disadvantaged socioeconomic and environmental situations and poor health conditions. Numerous research conducted in India and the west have revealed that the prevalence of alcohol usage is higher among tribal people.[3-6]

Alcohol dependence was shown to be more common among tribal people than among non-tribal people who were admitted for substance dependence in our facility.[7] It is to be determined why the same is the case. Formulating effective solutions for both prevention and treatment of substance misuse requires an understanding of the different dynamic aspects that contribute to it. Alcohol usage can start and continue for a variety of reasons. The therapies are influenced by the subjective factors that are categorized for alcohol use. Social enrollment may be the cause of alcohol usage because alcohol consumption is a culturally ingrained practice. The disinhibitory effects of alcohol may be able to overcome established low self-esteem as another possible cause. The motivations could change to dealing with the adverse emotions that might be brought on by long-term misuse.

Based on the patient's perception and attitude toward the alcohol-related problem, the interventions and the reasons given by the patients will vary. Patients are more open to change if they believe in the free-will concept.[8] The cultural influences on the attitudes of tribal people and non-tribal people may have preventative effects. The person's attitude and beliefs regarding alcohol consumption may have a direct impact on how severe their dependence becomes.

The purpose of the study was to assess the impact of ethnic origin on the subjective perceptions of alcohol and their implications for issues related to alcohol. We put out the hypothesis that patients' justifications for drinking alcohol and attitudes toward addiction varied among cultures. These variations may have an impact on how severely dependent they are on alcohol.

## MATERIALS AND METHODS

The Gautam Hospital and Research Centre in Jaipur served as the study's location. It was designed cross-sectional. Twenty patients from each of the tribal and non-tribal communities who were residents of the state of Rajasthan made up the study population. The institute's de-addiction facility was where the patients were admitted and where they stayed. Purposive sampling was used for the study. The study included patients who met the ICD-11 [9] diagnostic criteria for mental and behavioral disorders caused by alcohol dependence syndrome and active dependence. Patients with any co-occurring mental disease, substance abuse, or other problems were disqualified.

A unique clinical Performa was created with details on the sociodemographic and clinical factors. The patients' claimed reasons for drinking alcohol were evaluated using a modified version of the Reasons for Substance Use Scale (ReSUS)[10]. A five-point Likert scale was used to assess the 35 items on the questionnaire. It consisted of three subscales: Individual enhancement, Social enhancement/intoxication, and Coping with painful emotions. In evaluating the causes of substance use, the "Reasons for substance use scale" was found to have high reliability and validity.

All three of the subscales likewise displayed strong internal consistency.

The Alcohol Dependence Scale (ADS) was used to evaluate the severity of alcohol consumption.[11] When a quantitative assessment of the degree of alcohol dependence is required for basic research studies, the ADS is a commonly utilized scale. It consists of 25 items and addresses issues such as alcohol withdrawal symptoms, reduced drinking control, awareness of a drinking addiction, increasing tolerance to alcohol, and prominence of drink-seeking behavior. There are 25 items total, including dichotomous, three- and four-choice questions. The overall score is 0 to 47, with a higher number indicating greater reliance.

Using an Addiction Belief Scale, belief regarding addiction was evaluated.[12] The level of conviction in the disease-versus-free-will paradigm of addiction was measured using an 18-item Addiction conviction Scale (ABS; alpha=0.91). It is a standardized measure with 18 items that are assessed on a Likert scale of 1 to 5. The belief in the disease model is measured by nine items, while the belief in the free-will model is measured by nine items.

RESULTS

The current study's cross-sectional design included 40 patients who were alcohol dependent. There were 40 in all, with 20 being tribal and 20 being non-tribal. Both groups had similar mean ages, around 35 years, with the initiation of alcohol consumption occurring around 21 years earlier [Table 1]. There was no discernible difference between the two groups in terms of the length of dependency (P=0.19), the incubation of dependence (P=0.62), or the amount of money spent on alcohol (P=1.68).

With 13.152.52 and 7.65.36 years of education, respectively, non-tribal had a considerably higher educational status (P 0.01) than tribal. Compared to non-tribal patients (5%) [Table 2], a considerably higher number of tribal patients (40%) had a poorer socioeconomic status. A notable disparity in habitat was found, with 25% of the tribal people coming from rural areas compared to none of the non-tribal people. Additionally, 30% of tribal people worked in agriculture, compared to 55% of non-tribal people who were employed in private enterprise. Compared to non-tribal patients (15%), a significant number of tribal patients (50%) were still single. While all of the patients in the non-tribal areas were Hindu believers, 30% of the tribal people were Christians.

Table 3 compares the results of the subscales for the alcohol dependency scale, the belief in addiction scale, and the reason for substance use scale. Tribal were more likely than non-tribal to mention social enhancement as a reason for drinking alcohol (P=0.015), and coping with unpleasant emotions was a much higher reason. The belief

scale for addiction was similar between the two groups, with belief favoring the free-will model (mean=38 and 38.25) over the disease model (mean=8 and 8.5). In comparison to non-tribal (10.454.11), tribal (13.654.52) had considerably more severe dependence (P=0.025).

A comparison of the results [Table 4] for each test item reveals that a scale of the reasons why people use drugs, five strategies for coping with emotions, four social advancement variables, and the tribal, as opposed to non-tribal, assigned motivations for drinking alcohol to a single factor for personal enhancement. The Pearsons' correlation between clinical factors and certain RESUS subscales evaluated in the research population is shown in Table 5.

Both the incubation for dependence and the intake of alcohol for social enhancement had statistically significant negative correlations (0.389 and 0.365, respectively). A substantial positive link between dependence duration and intake for coping with upsetting emotions (0.467) as well as for personal growth (0.436) was discovered.

## DISCUSSION

The study's findings suggest groupings that are clinically comparable. Patients from both the tribal and non-tribal groups shared similar ages at which substance consumption started, lengths of time spent ingesting in a pattern of dependence, and times spent incubating between initial ingestion and ingestion in a pattern of dependency. The groups, however, varied in a number of sociodemographic traits. Tribal were less educated, many of them from rural areas, most were engaged in agricultural activities, and a higher percentage of patients came from lower socioeconomic status. Non-tribal were better educated, from urban areas, engaged in business or a professional job, and were from the middle economic status. This depicts the indigenous people's current deplorable situation in the state.[13]

With only 12.5% of patients coming from rural areas, the statistic also illustrates the lower service utilization by patients with alcohol dependence who reside in rural areas. Contrarily, 90% of the state's population resides in rural areas.

When examined on the alcohol dependence scale, the difficulties related to alcohol were more severe in the tribal despite having identical age and clinical profiles of start and duration. Such a variance might be brought about by socioeconomic and educational deprivation. Additionally, it has been proposed that differences in pharmacogenetics [14] and metabolic [15] traits that are biologically inherited in tribal people account for the lower alcohol tolerance in non-civilized populations.

The prevalence of drinking may be increased by cultural variables including traditional acceptance. Even while physiologically predisposed individuals are fairly distributed throughout these cultures, an increase in the population exposed to alcohol consumption may result in an increase in the number of individuals who develop pathological drinking. This study's findings that social enhancement rather than personal improvement is the primary motivation for alcohol consumption support the latter theory. The reasons given by tribal patients are

substantially more frequent than those given by non-tribal patients, including the desire to enjoy oneself with friends, to avoid social pressure, or to identify with a particular group. Thus, it is obvious that tribal people are more likely than other groups to become alcohol dependent.

Additionally, it was discovered that tribal people reported using alcohol more frequently than non-tribal people did to deal with their upsetting feelings. The literature frequently mentions the ongoing psychological issues caused by tribal people's poor self-esteem; historical oppression and prejudice have had a negative impact on their wellbeing.[5] The factors notably cited more frequently by the tribal include drinking when one feels horrible about oneself, when one considers the unfortunate events in the past, when one feels suspect or discriminating. Tribal have also mentioned sleep problems as a factor in their increased alcohol consumption.

The correlational investigation revealed that patients with severe dependence and a lengthy history of dependence admitted to drinking to deal with upsetting feelings. The considerations also indicate that sleep disruptions are a part of these painful feelings. Therefore, with an increase in alcohol intake, the painful emotions may even be alcohol withdrawal symptoms. As they have previously stated using alcohol to deal with upsetting emotions as a justification, this may once again demonstrate the lower tolerance of tribal people for alcohol. Both groups, however, have a weak belief in the biology or illness model of addiction that explains this.

Both tribal and non-tribal patients have a strong belief in the free-will paradigm and assume that using their willpower and discovering new coping mechanisms can help them get over their dependency. This implied a greater faith in the power of change, which may favor psychological treatments like motivational enhancement therapy. However, it also implied a lesser reliance on pharmaceuticals, which might result in poor adherence to treatment.

The study also found that alcohol was used more frequently for social enhancement and under peer and societal pressure the younger the age of initiation. However, when the time of intake increased, the patients discovered how to use it to suppress unpleasant feelings and improve themselves.

The duration between the first drink and the first time an individual used alcohol in a pattern of dependence was significantly reduced among those who consumed alcohol for personal betterment.

Conclusion

The prevention and treatment of alcoholism in the Indian context in general, and the state of Rajasthan in particular, are directly affected by these findings. Tribal' social, economic, and educational upbringing as a whole would have a direct impact on the primary prevention of alcohol-related issues. Tribal' alcohol consumption may decline if their psychological health is improved through a variety of interventions. It is imperative that people are informed about alcohol, its effects, and available treatment options, with a particular emphasis on rural areas. By distinguishing the symptoms from craving, intoxication, and withdrawal symptoms, educating the patients about the physiological elements of alcohol dependence may enable them to exert more control over their drinking

problem behavior. It would be preferable to focus on proper psychological interventions and therapy choices rather than pharmacological medicines.

Finding the biological variations among ethnic groups has to be encouraged in further research in order to advance our understanding of substance abuse. It would be preferable for studies to use community samples and have a bigger sample size.

REFERENCES

1. International Institute for Population Sciences (IIPS) and Macro International [Internet]. National Family Health Survey (NFHS-3), India, 2005-06: Jharkhand. Mumbai: IIPS; 2008 [Cited 2023 Jul 12]. Available from: http://www.nfhsindia.org/NFHS-3%20Data/Jharkhand_ report.pdf

2. Saxena S. Country profile on alcohol in India. In: Riley L, Marshall M, editors. Alcohol and Public Health in 8 Developing Countries. Geneva: World Health Organization; 1995. p. 38-60.

3. Giri DK, Chaudhary S, Manjhi G, Banerjee A, Mahto AK, Chakravorty PK. Utilization of psychiatric services by tribal population of Jharkhand through community outreach programme of RINPAS. Eastern J Psych 2007;10:25-9.

4. Neufeld KJ, Petersb DH, Rani M, Bonu S, Brooner RK. Regular use of alcohol and tobacco in India and its association with age, gender and poverty. Drug Alcohol Depend 2005;77:283- 91.

5. Mohindra KS, Narayana D, Anushreedha SS, Haddad S. Alcohol use and its consequences in South India: Views from a marginalised tribal population. Drug Alcohol Depend 2011;117:70-3.

6. Subramanian SV, Davey Smith G, Subramanyam M. Indigenous health and socioeconomic status in India. PLoS Med 2006;3:1794-804.

7. Prasad S, Sreeraj VS, Khess CRJ. Study of type of substance use in tribal and non tribal. Rinpas Journal, 2011;3:136-41.

8. Miller WR, Gayle BR, Scott TJ. Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. J Consult Clin Psychol 1993;61:455-61.

9. Saunders JB, Degenhardt L, Reed GM, Poznyak V. Alcohol use disorders in ICD-11: Past, present, and future. Alcoholism: Clinical and experimental research. 2019 Aug;43(8):1617-31.

10. Gregg L, Barrowclough C, Haddock G. Development and validation of a scale for assessing reasons for substance use in schizophrenia: the ReSUS scale. Addict Behav 2009;34:830-37.

11. Skinner HA, Horn JL. Alcohol Dependence Scale (ADS) Users Guide. Toronto: Addition Research Foundation; 1984.

12. Schaller JA. Addiction beliefs of treatment providers: Factors explaining variance. Addict Res Theor 1997; 4:367-84.

13. Office of the Registrar General, India [Internet]. 2011 [Cited 2023 Jul 12] Available from: http://censusindia.gov.in/ Tables Published/SCST/dh st Rajasthan.pdf

14. Li TK. Pharmacogenetics of responses to alcohol and genes that influence alcohol drinking. J Stud Alcohol 2000;61:5-12.

15. Suddendorf RF. Research on alcohol metabolism among Asians and its implications for understading causes of alcoholism. Public Health Rep 1989;104:615-20.