Factors Influencing Practice of Optimal Dietary Intake of Alcoholics under Rehabilitation in Asumbi-Homabay, Kenya

Lucy Amany Mutuli*, Peter Bukhala and Gordon Nguka
Masinde Muliro University of Science and Technology, Kakamega, Kenya

*Corresponding author: Lucy Amany Mutuli, Masinde Muliro University of Science and Technology, Kakamega, Kenya, Tel: +46 31 7864694; E-mail: amanyalucy@yahoo.com

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Abstract

Background: Optimal dietary intake in alcohol rehabilitation is a pathway that reflects self-care, commitment to staying sober and is a vital adjunct in effective alcohol rehabilitation.

Objective: This qualitative study sought to elicit facilitators and barriers that influence the practice of optimal dietary intake during the three months of alcohol rehabilitation.

Methods: A question guide was utilized to solicit information through in-depth interviews from 15 alcoholics and 5 health professionals until saturation point. Constant comparative approach was used to analyze verbatim transcripts obtained from in-depth interviews. This analysis entailed three stages including open, axial and selective coding.

Results: Recuperating alcoholics’ appreciated the health benefits of practicing optimal dietary intake in restoring their health, with health professionals being significantly supportive which translated into increased self-efficacy to practice of optimal dietary intake during alcohol rehabilitation.

Conclusions: The rehabilitation centres should have nutritionists besides other health professionals who can offer individualized nutrition services needed by the recuperating alcoholics.

Keywords: Alcoholism; Dietary intake; Rehabilitation; Psychosocial factors

Introduction

Alcoholism is a chronic relapsing disorder which alters brain functioning causing impaired judgment, reduced self-control, memory and learning functions [1]. These brain changes cause severe biochemical imbalances which renders the body more solely dependent on alcohol to make it feel stable and to alleviate the alcohol cravings [2]. Optimal dietary intake restores the physiological disruptions of the body using specific nutrients which the brain is wired on that affects how biochemical imbalances are restored and alcohol cravings are regulated [1]. Optimal dietary intake is a lifestyle treatment strategy that is aimed to help the alcoholic maintain sobriety.

In Kenya alcoholic treatment remains expensive, especially for inpatients who are rehabilitated for three months before discharge. However, the outcome of alcohol treatment reveals uncertainties through the relapse ranges of 60% to 90% after treatment [3,4]. Evidence shows that the emphasis on optimal dietary intake is very limited in these rehabilitation centers [5,6]. Yet these are strategies that can foster healthy lifestyle changes that contribute to long-term maintenance of recovery from alcohol. This setback is associated with sessions that have no input from the alcoholics but simply impose an idea that leaves the alcoholic with mixed perceptions regarding optimal dietary intake in effectively treating alcoholism and reducing relapse [3].

Given that, health professionals of the rehabilitation centers devise and transmit optimal dietary intake information without considering alcoholics’ cognitive and experiential aspects such as attitude, social perceptions, and self-efficacy and control beliefs [7]. These psychosocial attributes are significant in explaining how an alcoholic makes the decision or arrives at intention to practice optimal dietary intake during alcohol rehabilitation [8]. For instance, an alcoholics’ subjective likelihood about the likely outcomes of the optimal dietary intake determines their attitude towards it.

Moreover, alcoholics attempting to practice optimal dietary intake often fail as they have to comply with social expectations and encounter obstacles that may facilitate or impede their practice. An alcoholics’ decision to practice optimal dietary intake is determined by a combination of psychosocial factors which need to be identified and assessed. These psychosocial factors have been identified in a number of cognitive theories and in this context; Theory of Planned Behaviour.

This study intended to use the Theory of Planned Behaviour concepts’ attitude, subjective norm and perceived behavioural control as determinants of the practising of optimal dietary intake during alcohol rehabilitation. The researchers sought to establish the main themes underlying each psychosocial factor that influenced practise of optimal dietary intake during rehabilitation.

These results were more suggestive than affirmative limiting the possibility for quantitative comparisons but significant in development of an instrument for quantitative section.
Methods

Study area, design and population

Asumbi-Homabay located in Homabay County, Nyanza region of Kenya formed the study area mainly because of the existence of Asumbi rehabilitation center. This center was purposively sampled with the target that it receives numerous alcoholic patients both males and females from different parts of the country, offers standardized rehabilitation services to alcoholic rehabilitees and it's accredited by NACADA. This cross-sectional study was conducted between January and March, 2016 at Asumbi rehabilitation center. Sample criteria included female and male alcoholics aged 15-65 years who were admitted not more than a week prior to commencement of the data collection and those who voluntarily consented to participate in the study.

Alcoholics with active psychotic symptoms, addicts of substances other than alcohol and not intending to complete the three months of rehabilitation in Asumbi center were excluded from the study. A purposive sampling technique was used to select 20 out of 50 participants based on the inclusion criteria for this study, recommendations on qualitative research and utility of the TPB, and limitation of resources. The participants were elucidated for the purpose of the study before their participation in the in-depth interviews. Ethical approval was given by National Council for Science and Technology. Research authorization was granted by the National Agency for the Campaign against Drug Abuse. We sought informed consent from the respondents who were informed on the research procedures, details and assured of confidentiality.

Study instrument

An in-depth interview was conducted using a question guide developed based on Ajzen's theoretical framework. The main theme explored during the in-depth interview was psychosocial factors affecting practice of optimal dietary intake during alcohol rehabilitation. A total of 8 health professionals who were engaged in rehabilitating alcoholics at Asumbi Center were purposively selected and interviewed, the findings of these interviews were used to construct a question guide for the study. Two nutrition experts and a researcher then critically examined, discussed and provided inputs into the content of the question guide; they also assisted in refining it.

The question guide was then pretested on a sample of 10 alcoholics under rehabilitation at Asumbi Center who were randomly selected. The question guide was utilized to solicit information from in-depth interviews in groups consisting 15 alcoholics and 5 health professionals until saturation point. Verbatim transcripts were prepared regarding the factors these alcoholics encountered during their practice of optimal dietary intake while on rehabilitation. The procedure of preparing verbatim transcripts was essential to determine the salient consequences, referents and circumstances that form the belief structure underlying the intention to practice optimal dietary intake while on alcohol rehabilitation.

Data analysis

Constant comparative approach grounded in the Theory Planned Behaviour was used to analyze verbatim transcripts obtained from in-depth interviews. This analysis entailed three stages including open, axial and selective coding. In the open coding phase, verbatim transcripts generated during the in-depth interviews were examined and updated by listening to tapes to identify outstanding categories of information. In axial phase, the inductive coding categories were saturated and a set of categories developed where we identified several categories from the open coding list that were compared across to explore themes. The central phenomenon of interest was positioned at the centre of the theory and linked with other categories. In the selective phase, the inductive coding obtained was then organized into a coding paradigm that presents a theoretical model of the process under investigation.

Results

The interview responses provided a detailed source of information about behavioral beliefs, normative beliefs and control beliefs. Constant comparative approach analysis identified familiar verbatim transcripts on salient consequences (advantages/disadvantages), social referents (approval/disapproval) and circumstances (facilitator/barrier).

Behavioural beliefs

Participants were aware that to attain optimal dietary intake during alcohol rehabilitation they have to eat a balanced diet from variety of foods to achieve their diet adequacy. The importance of having a balanced diet included 'restoring organs affected by alcohol' 17 (87%) thus providing a 'state of wellbeing' 10 (50%). Diet adequacy defined as consumption of a meal that is satisfactory to an individual alcoholic was also recognized as a component for optimal dietary intake with the following reported benefits.

Basically, 7 (37%) reported that diet adequacy, 'helps to prevent muscle wasting, thus 'help to achieve metabolic demands' and 5 (25%) argued that it 'reduces fatigue'. There were also other recognized benefits, such as 'reduces nutrient deficiencies' reported by 10 (50%) and 'ability of diet adequacy to hydrate the body' was stated by 10 (50%), recognized that it 'improved brain chemistry'. These findings have been summarised in (Table 1).

<table>
<thead>
<tr>
<th>Factors</th>
<th>Responses percentage (%)</th>
<th>Frequency (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating a balanced diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restores tissues affected by alcohol</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Helps in detoxifying from alcohol</td>
<td>75</td>
<td>15</td>
</tr>
<tr>
<td>Corrects hepatic encephalopathy</td>
<td>62</td>
<td>12</td>
</tr>
</tbody>
</table>
Corrects neurological disorders 62 12
Restores organs affected by alcohol 87 17
Restores state of wellbeing 50 10

**Eating a variety of foods**
Avoids erratic blood sugars 50 10
Stabilizes neurotransmitters 62 12
Maintains mental clarity 37 7
Reduces cravings for calorie dense foods 62 12

**Diet adequacy**
Reduces fatigue 25 5
Prevents muscle wasting 37 7
Achieves metabolic demands 37 7
Reduces nutrient deficiencies 50 10
Hydrates the body 50 10
Improves brain chemistry 37 7

**Disadvantages**
Eating a balanced diet
Requires skills in dietetics 62 12
Requires nutrition knowledge 75 15
Eating a variety of foods
It's expensive to afford 62 12
It needs a lot of time to prepare 75 15
It's not practical 62 12

**Diet adequacy**
It's difficult to approximate 75 15
Fills the urge for alcohol intake 50 10

Note: The total frequency does not add up to 20 because participants listed several items for each question addressing beliefs.

**Table 1**: Attitudinal beliefs affecting optimal dietary intake in alcohol rehabilitation.

**Normative beliefs**
Normative beliefs are the social expectations of important people in alcoholic's life regarding the practice of optimal dietary intake with having a balanced diet from variety of foods and consuming a diet that is adequate. Significant others who encouraged eating of a balanced diet included 'health professional' 15 (75%), 'family members and friends' had a similar influence of 12 (62%), and 10 (50%) of colleagues.

Practically 12 (62%) of the participants reported 'medical professionals' as people whose opinion was most influential on their decision to consume a diet of varied foods. 'Family members' 12 (62%) and friends 10 (50%) were also influencing the alcoholics to have a diet of varied foods. The alcoholic's colleagues 10 (50%) and the environment 15 (75%) were reported as the disapproving group to eating a variety of foods during alcohol rehabilitation. The decision to attain diet adequacy was supported by medical professionals 10 (50%), family members 12 (62%), friends 7 (37%), and colleagues 7 (37%).

However, the environment 10 (50%) was not supportive of it. Medical professionals were reported to be most influential on the alcoholic's decision to practice optimal dietary intake, although alcoholics' were almost anonymous in their belief that the final decision would be with them (Table 2).
Table 2: Normative beliefs affecting optimal dietary intake in alcohol rehabilitation.

Control beliefs affecting optimal dietary intake

Beliefs that may encourage/discourage optimal dietary intake as described by the practice of eating a balanced diet from variety of foods and consuming a diet that is adequate were subsequently reported. Participants reported the facilitators of eating a balanced diet to include ‘nutrition knowledge in alcoholism’ 15 (75%) and ‘the will power to recover from alcoholism’ 12 (62%). The barriers of balanced diet consumption were ‘unavailability of foods’ 17 (87%) and ‘inaccessibility to services of a nutritionist’ 17 (87%). Facilitators of eating variety of foods in diets during rehabilitation included ‘nutrition knowledge in alcohol rehabilitation’ 15 (75%), and ‘alcoholics health’ 12 (62%).

The participants also reported ‘inaccessibility to services of a nutritionist’ 17 (87%) and ‘unavailability of diverse foods’ 15 (75%) as a significant inhibitors of consumption of diverse foods during alcohol rehabilitation since they only ate similar diets served to them and had no alternatives. It was acknowledged that “time to prepare the food” 7 (37%) was the least inhibitor of consumption of diverse foods since they consumed foods prepared by the kitchen section and were not allowed to cook for themselves.

Participant also reported ‘influences from mass media’ 10 (50%), ‘perceived misconception’ 10 (50%), ‘people to prepare the foods’ as other inhibitors of diverse food consumption. Participants reported ‘accessibility to sufficient diets’ 15 (75%) as a significant facilitator of diet adequacy even though not diverse. The least facilitator of diet adequacy was ‘alcoholic’s nutrition status’ reported by 10 (50%) of the participants (Table 3).
### Control Factors

<table>
<thead>
<tr>
<th>Eating a balanced diet</th>
<th>Facilitators</th>
<th>Response percentage (%)</th>
<th>Frequency (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unavailability of foods</td>
<td>Nutrition knowledge in alcoholism</td>
<td>87</td>
<td>17</td>
</tr>
<tr>
<td>Inaccessibility to services of a nutritionist</td>
<td>87</td>
<td>17</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Eating a variety of foods</th>
<th>Facilitators</th>
<th>Response percentage (%)</th>
<th>Frequency (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition knowledge in alcoholism</td>
<td>75</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Alcoholic's health after the period of alcoholism</td>
<td>62</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Confidence</td>
<td>50</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diet adequacy</th>
<th>Facilitators</th>
<th>Response percentage (%)</th>
<th>Frequency (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Knowledge in alcoholism</td>
<td>62</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Alcoholic’s nutrition status</td>
<td>50</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Supportive nutrition services</td>
<td>62</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Accessibility to sufficient diets</td>
<td>75</td>
<td>15</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Response percentage (%)</th>
<th>Frequency (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of nutrition services</td>
<td>87</td>
<td>17</td>
</tr>
<tr>
<td>Lack of capacity to quantify adequacy</td>
<td>75</td>
<td>15</td>
</tr>
<tr>
<td>Poor appetite for food</td>
<td>62</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: The total frequency does not add up to 20 because participants listed several items for each question addressing beliefs.

### Table 3: Control beliefs affecting optimal dietary intake in alcohol rehabilitation.

It was noted that familiarization with individual nutrition status was not of importance to the alcoholics. 'Lack of nutrition services' 17 (87%) was mentioned as a major hindrance to sufficient diet with 15 (75%) reporting the 'lack of capacity to quantify adequacy' as a barrier. 'Poor appetite for food' was also reported by 12 (62%) of the participants as hindering their diet adequacy. The information obtained from this coding phase was then organized into a coding paradigm that presents a framework of the process under investigation. In this way an attempt was made to build up a framework (Figure 1).
considered correct and appropriate behavior, and they emerge from the shared practices and expectations of the group members. When social and environmental support systems are in place, making healthful choices becomes possible and has an opportunity to improve alcohol rehabilitation. Perceived behavioral control represents participant's perceptions of control over practice of optimal dietary intake in the face of internal and external barriers; and the self-efficacy i.e., confidence that the participants have the ability to practice optimal dietary intake in spite of obstacles. It's essential for the recuperating alcoholics to receive individualized nutrition services from a nutritionist so that to improve their state of health and facilitate complete recovery from alcoholism. It's surprising that even though the recuperating alcoholics needed the support of a nutritionist, they had background information on role of nutrition in alcoholism. However, the complexity was to apply the knowledge into practise. This implies that they had low self-efficacy of practising optimal dietary intake as even illustrated in Table 3. This necessitates for a focus on rebuilding self-efficacy by creating realistic nutrition goals for participants [15]. On realization of the stated goals, participants should be offered affirmations for their accomplishments, being reminded that optimal dietary intake is possible regardless of present circumstances and despite previous track record.

Conclusion

This qualitative study established that deficiency of nutrition services was a significant barrier to the practise of optimal dietary intake during alcohol rehabilitation. This asserts that scarcity of nutrition services leaves the recuperating alcoholics with mixed perceptions of the composition of an optimal diet especially for their condition. Fostering strong combined relationships amongst family members, health professionals, friends, colleagues and environment is fundamental to support an alcoholic on recuperation. The rehabilitation centres should have nutritionists besides other health professionals who can offer individualized nutrition services and support needed by the recuperating alcoholics. Increased self-efficacy in relation to optimal dietary intake may translate into increased self-efficacy regarding to practice of optimal dietary intake during alcohol rehabilitation. Optimal dietary intake alone is insufficient to keep an alcoholic sober, and self-reported perceptions of self-efficacy may not predict long-term abstinence. Optimal dietary intake in alcohol rehabilitation is a pathway that reflects self-care, commitment to staying sober and is a vital adjunct in the complete recovery from alcoholism and reduction of relapse. This may decrease the prevalence of relapse after discharge from the rehabilitation centre.

Competing Interests

The authors declare that no conflict of interests exists.

Authors’ Contributions

All authors were involved with the drafting of the research paper, critically reviewed the manuscript and approved the final version submitted for publication.

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