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Slowing the Tide of Alcohol Use Disorders

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Abstract Alcohol use disorders (AUDs)—a spectrum including at-risk drinking, alcohol abuse, dependence, and addiction—is a highly prevalent problem worldwide with a substantial economic impact. The toll of alcohol on individual health and healthcare systems is devastating. Alcohol is estimated to be the fifth leading risk factor for global disability-adjusted life years. Tackling the problem of AUD requires a comprehensive strategy that includes solid action on price, availability, and marketing of alcohol. Restricting or banning alcohol advertising may reduce exposure to the risk posed by alcohol at the individual and general population level. Warning labels about the cancer risks associated with drinking have a high degree of public support and may be an inexpensive and acceptable way to educate the public. Religiosity may reduce risk behaviors and contribute to health decision making related to alcohol use.

Keywords Alcohol · Alcohol use disorders · Alcohol use disorder treatment · Adolescents · Religiosity

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Introduction

Worldwide, alcohol sits in the top five causes of death and disability. Alcohol contributes to over 200 diseases and injury-related health conditions, most strikingly alcohol dependence, liver cirrhosis, injuries, and cancers. In 2012, about 3.3 million deaths, or 5.9 % of all global deaths and 139 million DALYs (disability-adjusted life years), were attributable to alcohol consumption (WHO 2014).

Alcoholism, the chronic and progressive illness associated with alcohol consumption, along with alcohol abuse, under-age, and binge drinking, comprise an array of alcohol problems in the USA. Overall, about 16.6 million Americans older than 18 years are estimated to have an AUD (Editorial, Lancet 2015). Alcohol use disorder is a major public health issue, costing the USA economy \$223 billion a year and the UK economy more than £21bn (€29bn; \$32bn) a year (Gilmore 2015). An extensive evidence in the literature confirms the association between alcohol use and mortality. Many current drinkers, even light drinkers, report drinking-related problems including uncontrollable drinking, prolonged misuse of alcohol, reduced activities because of drinking, preoccupation with drinking, and withdrawal symptoms related to drinking (Rogers et al. 2015).

The Scope in Adolescents

Research suggests that young people have a peculiar alcohol-related risk profile compared to older alcohol users, with adolescents more liable to experience harms such as alcohol-related violence and injuries. In 2013, more than 5 million people between 12 and 20 years of age reported binge drinking, and over a million young people in this particular age group reporting being heavy drinkers. Even with a legal drinking age of 21 years, many adolescents and young adults not only have access to alcohol but are imbibing at levels that predispose them to increased risk of physical injury (both themselves and others) and psychological problems. People who begin drinking before 15 years of age are at five times increased risk of developing alcohol abuse later in life than those who did not start at such age. Children of people who abuse alcohol are at even higher risk, with a more likelihood of early drinking earlier and developing alcohol problems sooner (Editorial, Lancet 2015).

A cross-sectional study from Lebanon on 1235 university students showed that harmful alcohol drinking was mostly affected by peers' behavior. Certain beliefs concerning alcohol consumption such as ignoring the dangers of alcohol consumption and higher frequency of consumption with friends were factors associated with harmful drinking (Salamé et al. 2013).

Young people who are exposed to alcohol advertising are more likely to start drinking, and those who already drink are liable to drink at much higher levels. It is thus so clear that a range of preventive health policies should be implemented, particularly targeting adolescents and young adults, if we are keen on addressing the morbidities and mortality associated with AUD (Scholes-Balog et al. 2012).

AUD in Elderly

Alcohol problems in people aged 65 years or over, in the United Kingdom and globally, have risen steadily over the past decade. These are a common but under-diagnosed and under-recognized problem. A recent Royal College of Psychiatrists Report noticed that there has been an increase in the number of people drinking above the weekly recommended limits by

60 % in men and 100 % in women between 1990 and 2006. The Invisible Addicts report (RCPsych 2011) recommends screening every person aged over 65 years as part of a routine health check (Thompson 2014). It has been estimated that around 20 % of patients attending their GP in the UK are at risk from their drinking or have an alcohol use disorder. Without using specific screening tools, GPs may typically detect only 40 % of cases they see but miss the majority. The single question with the highest sensitivity was a modification of the Single Alcohol Screening Question (M-SASQ): “How often do you have six or more standard drinks on one occasion?” with monthly or more frequently taken as a positive result. A positive, simple alcohol screening test should be followed up with a more in-depth screening questionnaire, the so-called algorithm approach (Taylor et al. 2014).

Are We Doing Enough?

Besides the social and economic consequences of uncontrolled alcohol drinking, these disorders annually account for one in 10 deaths, through accidents and related medical problems such as cirrhosis. Despite the significance of these disorders, less than a third of patients with alcohol use disorders receive any treatment, and fewer still receive evidence-based treatment. Despite the fact that Food and Drug Administration-approved medications with proven efficacy in reducing relapse, fewer than 10 % of patients are treated with such medications (O'Brien 2015).

There is a solid international evidence from different countries and cultures, on what works in reducing alcohol-related harm, but, unfortunately, it is quite clear that this evidence is not translated into effective public health policies (Gilmore et al. 2013a).

Alcohol awareness can and should mean several facts. First, an appreciation of the magnitude of alcohol-related illnesses is fundamental to reduce the social and financial impact. Second, alcoholism and alcohol abuse are treatable. Since the primary treatment goal for those misusing or dependent on alcohol is abstinence, it follows that the fundamental public health goal should be in investing genuine efforts in prevention (Editorial, Lancet 2015).

Several studies from different countries have consistently shown that even small increases in the price of alcoholic beverage reduce both consumption and its related hazards (long term and short term). Restriction on the physical availability of alcohol is also well known to work. This can be achieved by some measures, with the most successful known to be restricting hours and days of sale, and restricting the legal drinking age for purchase or consumption of alcohol (Anderson et al. 2009).

Two measures are shown to be quite effective public health interventions for reducing alcohol-related harm, price regulation and trading hour restrictions. The best available evidence points to increased consumption and harm arising from longer trading hours. An independent group of experts (steered by the UK Alcohol Health Alliance) has recently published a very comprehensive, evidence-based alcohol strategy (Gilmore et al. 2013b) as a model for the UK and beyond, with well-defined recommendations on how to reduce alcohol-related sequel among the population.

Warning Labels on Alcohol Beverages

Most people know that heavy alcohol drinking can lead to health problems, but many people might not realize that drinking alcohol can raise their cancer risk. It is estimated that 3.6 % of all cancer cases and 3.5 % of cancer deaths worldwide are attributable to

consumption of alcohol (Boffetta et al. 2006). A recent study found that one in 10 of all cancers in men and one in 33 in women were caused by alcohol. When it comes to cancer, no amount of alcohol is safe that is the conclusion of the 2014 World Cancer Report (WCR), issued by the World Health Organization's International Agency for Research on Cancer (IARC) (Rehm et al. 2014).

In an attempt to further reduce alcohol-related harms, many health and policy researchers are urging for the implementation of mandated health and safety warning labels on alcoholic beverages. Alcohol warning labels that alcohol causes cancer have been an increasingly popular alcohol policy initiative. Warning labels can be ineffective, but the experience from tobacco labels suggests that effective warning labels are possible. The introduction of alcohol warning labels may increase awareness about the risks of alcohol consumption among adolescents; however, alcohol warning labels should be considered as only one aspect of a wide range of other proven strategies to change the knowledge, attitudes, and behavior. Developing direct and pictorial health warnings, increasing the visibility of these warnings on alcohol products could all advocate the case for stringent alcohol health warnings policies (Al-hamdani 2014). According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects and "Alcohol abuse is dangerous to your health" (Scholes-Balog et al. 2012). Louise et al. thoroughly discussed, whether it is ethical to add a label on alcohol beverages warning the consumers about the risk of cancer associated with its use. The concept of warning labels on alcohol beverages may be advocated since giving sincere advice enjoys an ethical support (Louise et al. 2015).

Is There a Role for Religiosity?

A survey of over 1000 young people from Leicestershire (UK) revealed significant differences between ethnic groups regarding both their attitudes and the frequency of alcohol consumption. Differences in attitudes to the consumption of alcohol were found among Sikhs, Hindus, and Muslims, with the Muslims demonstrating special respect to their religion's prohibition of drinking alcohol. However, the level of drinking by the Hindus and Sikhs was not much greater than that of the Muslims. The three groups had a similar frequency of alcohol consumption that was markedly lower than that reported by the White 15–16-year-olds (Denscombe 1995).

In Israel, for example, there is an increasing exposure of the conservative Arab sector to the Western culture that might impact the drinking patterns of these two populations. Adherence to religious traditions is still considered as a barrier against drinking among both Arabs and Jews (Neumark et al. 2001). Because of Muslim laws prohibiting alcohol consumption, alcohol consumption is not high. However, it does exist particularly among young men, and when they drink alcohol, they tend to drink heavily, more than what the Arab Christians do (Baron-Epel et al. 2015).

In a study of 1837 Lebanese university students (Christians, Muslims, and Druze), it was found that students belonging to conservative religious groups are less likely to try alcohol. Religiosity is still, however, related inversely to alcohol-related problems, even among drinkers (Ghandour et al. 2009).

A recent study of substance abuse in adolescents from Lebanon versus the U.S.A. showed that Muslim adolescents had significantly lower rates of alcohol and substance use than Christians in both Lebanon and Los Angeles. The longer they live in the U.S.A., the

more the likelihood of abuse for both Muslims and Christians. Attachment to God and family has been shown to negatively associate with substance abuse (Badr et al. 2014).

Data from emerging adults (ages 18–29, $N = 900$) in the National Comorbidity Survey Replication Study were used to examine the influence of childhood adversity, childhood and emerging adult religiosity and religious-based decision making, on alcohol use. Childhood religiosity was shown to be protective against early alcohol use and progression to later abuse or dependence but did not significantly countervail the influence of childhood adversity on early heavy drinking. Religiosity in emerging adulthood was noted to be negatively associated with alcohol use disorders. Mental health providers should try to integrate the clients' religiosity and spirituality practices and beliefs in the treatment settings if the clients exhibit such interest (Porche et al. 2015).

Religiosity may be particularly protective during the transition period from adolescence to emerging adulthood (Ohm 2003). A review by Rew and Wong (2006) exploring the impact of religiosity on health attitudes and behaviors among such age group showed that religiosity had a positive impact on health behaviors and alcohol use in 84 % of the studies reviewed.

Conclusion

Alcohol use disorders are common and devastating diseases. There are no easy solutions. In fact, it is a multifactorial problem, and each aspect should be addressed individually, and seriously, by both the government and public at large. Evidence that is banning alcohol advertising is likely to be an efficient measure is reflected in WHO strategy documents on the harmful use of alcohol. However, the control of alcohol advertising in many countries, unfortunately, remains an industry self-regulated system.

Governments should take all initiatives to reduce alcohol sales, consumption, and related harm. Nobody can afford the interests of big companies to override public health and well-being. For the time being, the public health community is “going it alone,” in the hope that policy makers will follow, and since the primary treatment goal for those misusing or dependent on alcohol is abstinence, the primary public health goal should be in investing efforts in prevention of this major health problem. While we are trying to do that, we should pay more attention to the needs of the victim by the education of the masses as human sufferings continue to grow and thousands of lives being lost or crippled daily. All of these require motivation, perseverance, and commitment from all of us.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Human and Animals Rights This article does not contain any studies with human participants or animals performed by any of the authors.

Informed Consent No Human participants in this review article. So no need for consent.

References

Al-hamdani, M. (2014). The case for stringent alcohol warning labels: Lessons from the tobacco control experience. *Journal of Public Health Policy*, 35(1), 65–74.

- Anderson, P., de Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44, 229–243.
- Badr, L. K., Taha, A., & Dee, V. (2014). Substance abuse in Middle Eastern adolescents living in two different countries: Spiritual, cultural, family and personal factors. *Journal of Religion and Health*, 53(4), 1060–1074.
- Baron-Epel, O., Bord, S., Elias, W., Zarecki, C., Shifan, Y., & Gesser-Edelsburg, A. (2015). Alcohol Consumption among Arabs in Israel: A qualitative study. *Substance Use and Misuse*, 50(2), 268–273.
- Boffetta, P., Hashibe, M., La Vecchia, C., Zatonski, W., & Rehm, J. (2006). The burden of cancer attributable to alcohol drinking. *International Journal of Cancer*, 119(4), 884–887.
- Denscombe, M. (1995). Ethnic group and alcohol consumption: The case of 15–16-year-olds in Leicestershire. *Public Health*, 109(2), 133–142.
- Ghandour, L. A., Karam, E. G., & Maalouf, W. E. (2009). Lifetime alcohol use, abuse, and dependence among university students in Lebanon: Exploring the role of religiosity in different religious faiths. *Addiction*, 104(6), 940–948.
- Gilmore, I. (2015). Alcohol—Who is paying the price? *BMJ*, 350, h2974.
- Gilmore, I., Anderson, W., Bauld, L., et al. (2013a). *Health first: An evidence-based alcohol strategy for the UK*. Stirling: University of Stirling.
- Gilmore, W., Chikritzhs, T., & Gilmore, I. (2013b). Alcohol: Is the evidence base guiding public policy? *International Journal of Evidence-Based Healthcare*, 11(2), 85–86.
- Lancet [No authors listed]. (2015). All in for alcohol awareness (Editorial). *Lancet* 385(9977), 1477.
- Louise, J., Elliott, J., Olver, I., & Braunack-Mayer, A. (2015). Mandatory cancer risk warnings on alcoholic beverages: What are the ethical issues? *The American Journal of Bioethics*, 15(3), 3–11.
- Neumark, Y. D., Rahav, G., Teichman, M., & Hasin, D. (2001). Alcohol drinking patterns among Jewish and Arab men and women in Israel. *Journal of Studies on Alcohol*, 62(4), 443–447.
- O'Brien, C. (2015). In treating alcohol use disorders, why not use evidence-based treatment? *American Journal of Psychiatry*, 172(4), 305–306.
- Ohm, R. (2003). The African American experience in the Islamic faith. *Public Health Nursing*, 20(6), 478–486.
- Porche, M. V., Fortuna, L. R., Wachholtz, A., & Stone, R. T. (2015). Distal and proximal religiosity as protective factors for adolescent and emerging adult alcohol use. *Religions (Basel)*, 6(2), 365–384.
- Rehm, J., & Shield, K. (2014). Alcohol consumption. In B. W. Stewart & C. B. Wild (Eds.), *World cancer report*. Lyon: International Agency for Research on Cancer.
- Rew, L., & Wong, Y. J. (2006). A systematic review of associations among religiosity/spirituality and adolescent health attitudes and behaviors. *Journal of Adolescent Health*, 38, 433–442.
- Rogers, R. G., Boardman, J. D., Pendergast, P. M., & Lawrence, E. M. (2015). Drinking problems and mortality risk in the United States. *Drug and Alcohol Dependence*, 151, 38–46.
- Salamé, J., Barbour, B., & Salameh, P. (2013). Do personal beliefs, and peers affect the practice of alcohol consumption in university students in Lebanon? *Eastern Mediterranean Health Journal*, 19(4), 340–347.
- Scholes-Balog, K. E., Heerde, J. A., & Hemphill, S. A. (2012). Alcohol warning labels: Unlikely to affect alcohol-related beliefs and behaviors in adolescents. *Australian and New Zealand Journal of Public Health*, 36(6), 524–529.
- Taylor, C., Jones, K. A., & Denning, T. (2014). Detecting alcohol problems in older adults: Can we do better? *International Psychogeriatrics*, 26(11), 1755–1766.
- Thompson, J. (2014). Identifying at-risk drinkers in primary care. *Practitioner*, 258(1774), 5.
- World Health Organization (WHO). (2014). Global status report on alcohol and health. http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.pdf.