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Caretaker Burden in Alcohol Dependence Syndrome in Nepal: A Teaching Hospital Based Study

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Abstract

Background: Family plays a key role in the care of patients with mental illnesses. This is especially very true in Nepal because of various factors like the tradition of interdependence, the concern for the family, and the lack of sufficientmental health professionals. **Subjects and Methods:** A total 75 patients diagnosed with alcohol dependence syndrome and their 75 caretakers according to inclusion and exclusion criteria. **Results:** Out of the cases of 75 cases of alcohol dependence syndrome taken for study, majority were found to be in the age range of 30–39 years (37.3%) followed by 40–49 years (54.7%). In total, 61.6% were Upper caste, 29.3% Adibasi-Janajati and 9.3% were from a Others. Around 60.0% cases belonged to a nuclear family, 38.7% to joint family, and 1.33% had extended family.40(53.3%) patients reported mild dependence, 23(30.7%) patients moderate dependence, 11(14.7%) patients severe dependence, and only 1(1.3%) patients very severe dependence. **Conclusion:** We found that there is significant burden for caretakers. In addition, the caretaker burden and severity of dependence were positively correlated with high level of significance. Therefore, while treating alcoholics, it is important to alleviate the burden of the caretakers which in turn will lead to better treatment effectiveness.

Keywords: Alcohol Dependence Syndrome, caretaker and Burden.

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Introduction

Family is the key resource in the care of patients including those with mental illness in Nepal. The term family has its origin from the Latin term ‘familia’ that denotes a household establishment. The concept of family has undergone many transitions through various civilizations with time. Family nowadays denotes a group that consists of parents, their children and nearby relatives of same bloodline.[1] Family plays an important role in providing not only social and financial support to an individual but also helps in dealing with emotional crisis. It has been seen that any kind of illness, acute or chronic besides affecting the individual also has substantial impact upon the family. Alcohol dependence has been a major social and personal threat in most countries. According to Global Status Report on Alcohol, Alcohol Use Disorders (AUDs) account for 1.4 per cent of the global disease burden.[2] Alcohol dependence is considered as a “family disease.” Alcohol dependence affects the individual as well as those around them in terms of occupational and social dysfunction, physical and emotional distress, and financial burden which has a serious impact on the lives of the significant others.[3] An earlier study from Nepal among intravenous drug users and alcohol dependent patients found increased caretaker burden in both the groups; however the burden was more with intravenous drug users than alcohol dependent patients. The study also reported that the spouses of both alcohol dependent patients and also intravenous drug abusers exhibited more tolerance and less perceived burden towards the substance use when compared to the other family members like parents, children, and siblings.[4] In another smaller-scale cross-sectional study of alcohol-dependent patients in Eastern Nepal, 38 out of 60 patients (63.3 %) had one or more psychiatric disorders.[5] A study from India comparing the family burden of patients with schizophrenia, alcohol dependence, and opioid dependence by using the Family Burden Interview Schedule (FBIS) showed moderate to severe burden in all the three groups.[6] Another study assessed the severity of burden in wives of opioid dependence patients and reported severe burden in both objective and subjective scales.[7] A study from Chandigarh which assessed the family burden using FBIS in 120 subjects of alcohol and/or opioid dependence reported that almost all (95–100%) caregivers had severe burden.[8] The

present study aims at measuring the various aspects of burden on the caretakers or family members of alcohol dependent patients.

Subjects and Methods

The study was conducted in the Department of Psychiatry, Nepal Medical College and Teaching Hospital, Kathmandu, Nepal. This study consists of 75 patients diagnosed with alcohol dependence syndrome and their 75 caretakers during the period from February 2017 to March 2018. The study was approved by the Ethics Committee for Research of the Nepal Medical College Teaching Hospital. All subjects and/or their proxies signed an informed consent term.

Inclusion Criteria

- >20 years of age who were diagnosed to have alcohol dependence syndrome as per ICD-10 criteria and their caregivers who were more than 25 years of age. Patients and caregivers gave consent.

Exclusion Criteria

- Patients and caregivers who had any other psychiatric comorbidity or those who are physically too ill to participate in the study were excluded. Caretakers with alcohol dependence and patients with any other dependence other than alcohol and nicotine were also excluded.

Tools used for Assessments

1. ICD-10 criteria for diagnosis of schizophrenia and dementia.[9]
2. Socio-demographic Sheet: This is used to collect various socio-demographic details of caregivers.
3. Mini-Mental State Examination (MMSE): This scale has been developed by Folstein et al.[10] This scale has 11 items, which was used in this study for screening out cognitive status of the caregivers, to ruled out cognitive disturbances.
4. Family Burden Interview Schedule (FBIS): This is developed by Pai and Kapur in 1981. This scale is widely used to measure caregiver stress of those who are performing care giving activities of any family member with any chronic illness. It measures both subjective and objective burden of caretakers. This is a semi-structured interview schedule comprising 24 items grouped under six areas viz. financial burden, disruption of routine family activities, family leisure, family interactions, effect on physical and mental health of others. Rating of burden is done on a three-point scale for each item and a standard question to assess the 'subjective' burden is also included in the schedule. The validity and reliability of the scale has been shown to be satisfactory. The inter-rater reliability for all items was reported to be more than 0.78 by the authors of the schedule.[11]
5. WHO Quality of Life Bref (WHOQOL Bref) scale: This scale is developed by World Health Organization. This consists of 26 items that concerns with the four domains (Physical, Psychological, Environmental and Social relations) of quality of life of a person.[12]

Statistical analysis

Data was analyzed by using SPSS, Version 16.0. The qualitative variables were compared using Chi-square and the quantitative variables were compared by using t test. The relationship between domains of burden and quality of life of caretakers of each group were analyzed by using Pearson correlation.

Results & Discussion

As depicted in [Table 1] Socio-demographic and Clinical Variables of the Cases and their Caretakers: in our study, all the 75 patients were males and most of the patients were in the fourth and fifth decade of life and the mean±Sd age of the participants was 36.23 ± 12.01.. Out of the cases of 75 cases of alcohol dependence syndrome taken for study, majority were found to be in the age range of 30–39 years (37.3%) followed by 40–49 years (54.7%). In total, 61.6% were Upper caste, 29.3% Adibasi-Janajati and 9.3% were from a Others. Around 60.0% cases belonged to a nuclear family, 38.7% to joint family, and 1.33% had extended family. Majority of the cases were married 64.0%, 34.7% unmarried and 1.33% were others. In our study it was found that 13.3% cases had received primary education, 37.3% had second¬ary education, and 12.0% graduates with only 8.0% illiterate cases. Most of the cases in the study were unskilled workers 34.7% followed by unskilled workers 24.0%, Unemployed 20.0% and Clerical/shop owner (18.7%) where only 5.3% cases were Professional. When the socio-economic status was looked at, it was found that 37.3% cases were from lower/lower middle strata, 40.0% from upper lower socio-economic status, and 22.7% from upper middle/upper strata.

Table 1: Sociodemographic factors of the patients and caretakers.

Variables		Patients n=75 (%)	Caretakers n=75 (%)
Age in (Mean±Sd)		36.23 ± 12.01	38.5 ± 15.3
Age Range	20-29	03	4%
	30-39	28	37.3%
	40-49	41	54.7%
	50-59	02	2.7%
	60-70	01	1.3%
Sex	Male	71(94.6%)	25(33.3%)
	Female	4(5.4%)	50(66.7%)
Marital Status	Unmarried	26(34.7%)	02(2.7%)
	Married	48(64.0%)	52(69.3%)
	Others	01(1.3%)	21(28.0%)
Education	Illiterate	06(8.0%)	08(10.7%)
	Primary school	10(13.3%)	18(24.0%)
	Middle school	22(29.3%)	14(18.7%)
	Higher secondary	28(37.3%)	25(33.3%)
	Graduate	09(12.0%)	10(13.3%)
Occupation	Unemployed	15(20.0%)	36(48.0%)
	Unskilled labour	26(34.7%)	08(10.7%)
	Skilled labour	18(24.0%)	17(22.7%)
	Clerical/shop owner	12(16.0%)	14(18.7%)
	Professional	04(5.3%)	0(0.0%)

Family	Nuclear	45(60.0%)	45(60.0%)
	Joint	29(38.7%)	29(38.7%)
	Extended	01(1.33%)	01(1.33%)
Religion	Upper caste	46(61.6%)	46(61.6%)
	Adibasi-Janajati	22(29.3%)	22(29.3%)
	Others	07(9.3%)	07(9.3%)
Income in (Mean±Sd)		7,649 ± 2131	4300 ± 1214
Socioeconomic status	Upper	03(4.0%)	4(5.3%)
	Upper middle	14(18.7%)	14(18.7%)
	Lower middle	24(32.0%)	23(30.7%)
	Upper lower	30(40.0%)	29(38.7%)
	Lower	04(5.3%)	5(5.3%)
Locality	Urban	47(62.7%)	45(60.0%)
	Rural	28(37.3%)	30(40.0%)
Relationship of the caregiver with patient	Parent	-	23(30.7%)
	Spouse	-	48(64.0%)
	Sibling	-	3(4.0%)
	Others	-	1(1.3%)

[Figure 1] shows the, 40(53.3%) patients reported mild dependence, 23(30.7%) patients moderate dependence, 11(14.7%) patients severe dependence, and only 1(1.3%) patients very severe dependence. The average score on SADQ was 18.26 ± 10.02. Nearly 80% of alcohol dependent patients were drinking minimum of 180ml of Nepal Made Foreign Liquor (NMFL) per day which contains about 76.5ml of absolute alcohol. NMFL is a distilled spirit (i.e., brandy, whiskey, and rum). Our patients consumed predominantly brandy. Each 100ml of NMFL contains 42.5% of absolute alcohol. Almost 40% of dependent patients were drinking around 360ml of NMFL every day and 8% of dependent patients were drinking 750ml of NMFL per day. Tremors were commonly noted in most of the patients.

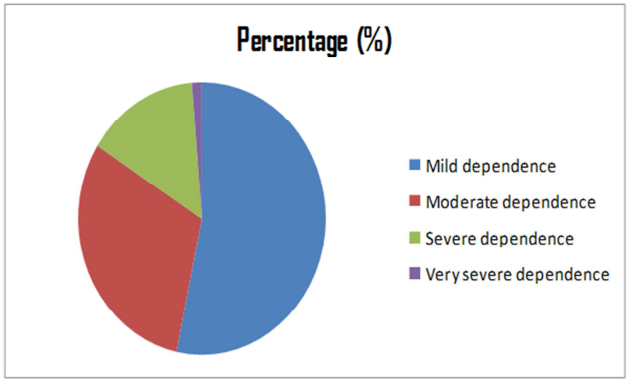

Figure 1: Classification of alcohol dependent patients based on severity.

We found the correlation between the severities of patient's dependence with their caretaker burden was statistically analyzed. The results showed that there was significant correlation of +0.52 at *p* value <0.01 between the severity of dependence and the total objective burden scores. Caregiver subjective burden score also significantly correlated at +0.38 with p value <0.01. In the domain scores, the correlation was strongest for financial burden compared to other domains with the severity of dependence at correlation coefficient of +0.32 with the level of significance p <0.01. In addition, all the other domains in the FBIS also significantly correlated with the dependence severity.

Alcohol dependence is a severe mental health problem associated with health issues and social and financial burden not only for the patient but also for the family members. In addition, it assumes greater relevance to predict the outcome of the alcoholism. Our study assessed the burden experienced by caretakers of treatment seeking alcohol dependent subjects. Of the 75 subjects in our study, all of them were males which show that in our centre mostly males seek deaddiction treatment which is same as in other part of country. Much of the study's sociodemographic profiles of the caretakers were matched with one similar study done in Ranchi, India13, in the past. Majority of the caretakers were females; they were predominantly spouses of the patient. In a country like us, there is a cultural belief that men should be the breadwinner of the family and probably this would have shifted the responsibility of caring for the sick to the women.[13] A western study also reported that the female affected family members exceed male caretakers particularly partners were more than mothers and sisters. They also had significant male affected family members such as father, uncle and brothers who are slightly different from our study sample.[14]

In Nepal, unlike western population the people mostly live in joint families. Though our study samples living in nuclear families were slightly more than those living in joint families, the difference is less. However in our study the proportion of families living in joint family was much higher than the western population. In the joint family morbidity of patients could easily shift to their family members since everyone were exposed to the patient's alcohol related problems on a day to day basis. Their daily activities got disrupted frequently and all family members may get exposed to physical injuries due to violent behavior of patients under intoxicated state. In addition children in the family would have a poor role model by seeing the patient's behavior. Though most of our subjects came from urban background, majority of them belonged to lower class to lower middle income group. This is probably due to rapid expansion of the city with migrants from adjacent town. In our study, the caretakers experienced significant burden in various domains due to patient's alcoholism. It is probably because the spouses were dependent on the patients for various reasons like finance and child-rearing. Moreover, the societal views of being separated from the husbands suffering from alcoholism will cause them more mental trauma and hence most of them chose to live with the patients even though they experienced significant burden. More than 3/4 of our caretakers were wives having children of varying age. Patient's dependence severity was positively correlated with their caretakers' burden at the correlation coefficient value of +0.52 which means that the correlation was highly significant. The various domains such as financial burden, disruption of routine family activities, disruption of family interaction, effect on the physical health of others, and effect on the mental health of others

were also positively correlated with highly significant correlation coefficient value. This is possibly due to the fact that, in most of the families, patients were the sole earning member of the family and majority of the caregivers were unemployed. Also money was deviated for procuring the substance and treatment expenditures.15 Frequent arguments, verbal abuse, and physical abuse of family members under the influence of alcohol caused significant disruption in the communication between family members, disruption in their leisure activity, and significant adverse impact on caregiver physical and mental health.

Conclusion

In conclusion, we found that there is significant burden for caretakers. In addition, the caretaker burden and severity of dependence were positively correlated with high level of significance. Therefore, while treating alcoholics, it is important to alleviate the burden of the caretakers which in turn will lead to better treatment effectiveness. Also the severity of family burden is greatly influenced by the socio-demographic variables of the families as well as the duration of the substance dependence of the cases.

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