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Original Research Article

A Cross-Sectional Research on the Financial Impact on Family Members of Alcohol-Dependent Care Givers

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Abstract

Introduction: In India, the primary source of treatment for patients, especially those with alcoholism, is family. Almost all facets of family life—personal, social, and psychological—are impacted by an alcoholic. This results in issues, challenges, or undesired procedures that affect family members and put a tremendous load on those who are caring for them. The study's objective was to evaluate how much family responsibility fell on the patients' primary caregivers who were also alcohol-dependent.

Methods: A hospital-based study was carried out in a training and treatment facility for drug addiction in India. A purposive sample strategy was used to choose 200 alcohol-dependent patients from the outpatient department (OPD) at tertiary care centre in Ahmednagar who had access to main caregivers. 200 caregivers (one form per patient) were enrolled in the study with the patient's and caregiver's informed consent. Using the Family Hardship Interview Schedule, the pattern of burden experienced by family members of those with alcoholism was evaluated (FBIS).

Results: According to the findings, most carers were housewives. There was a moderate to severe level of load across all care domains. Alcoholism was linked to financial stress on the family. It revealed a significant burden for low-income households living in rural areas.

Conclusion: Alcoholism negatively impacts both the patient and their life.

Keywords: Income, Homemaker, Spouse, Rural.

Introduction

Family members are crucial for an individual's mental stability as well as their social and economical support. The Indian culture of dependency, the concern of close family members at difficult times, the lack of mental health experts, and other factors have all been cited as reasons why family is the most important resource in care [1]. Both physical and mental disorders, whether acute or chronic, have a significant impact on family stress [2]. Especially in the Indian setting, the family has long been recognised as a crucial institution for support and care. There are around 5,000 mental health experts in a nation with more than 1.3 billion people, where the family unit plays a considerably larger role. The community and family play a significant part in a person's mental healthcare since there is a severe dearth of mental health facilities and specialists. Alcohol consumption problems are 4.7% common in India [3]. Substance abuse problems are a double-edged sword that affect the person and his family. The term "burden of care" refers to issues, challenges, or negative consequences that have an impact on the life of the dependent patient's family

members [4]. It is also known as the financial burden, social isolation, and psychological toll that sufferers' relatives must face. The caregiver's impression of his or her own physical and mental health is included in the subjective burden, but so is the caregiver's view of the caregiver's own physical and mental health [5.] Families with alcoholic dependent members struggle with communication issues such poor family cohesion, a lack of ability to solve conflicts, and low family congeniality [6,7]. The spouse of a person with alcoholism typically experiences a lot of stress. Domestic abuse, unhappy marriages, and marital strife are all correlated with alcohol misuse [8]. If there is an alcoholic parent in the home, there will be poor parenting, mistreatment of the kid, and disrespect [9]. Physical, emotional, financial, social, and vocational dysfunction are all negative effects of illness that have an impact on both the person who is ill and those who are close to them. This results in considerable issues, complexities, or unfavourable situations for both the individual and others. Caregiver load has been used to characterise the negative impact of these challenges and their outcomes [4]. The family environment, including the coping mechanisms used by various family members and their tolerance of the patient's disruptive behaviour, heavily influences the burden [10]. Although it is well acknowledged that alcohol misuse is a complicated biopsychosocial phenomena, drug abuse is seen as a "family illness." [11] A member of the family who struggles with alcoholism has an impact on practically every element of family life, including social and interpersonal interactions, financial stability, and leisure activities. Substance abuse impacts family members, exacerbates family tensions, and adds to the obligations already placed on the family. The difficulties of family life have historically received less attention since substance abuse has often been seen as an individual issue.

In the past, research on families with dependent members has almost solely focused on the family and the family process as an aetiological factor influencing the subject's drug use [12]. The load is more frequently connected to the person's disruptive behaviour and their financial struggles as a result of lost income and/or money being diverted to support their substance abuse [13]. Families with alcoholics are more likely to experience stressful life events, suffer from physical and mental illnesses, and need medical services more frequently. This is especially true for spouses [14-19]. For families with alcohol dependency, there was observed to be a relatively significant objective and subjective burden. According to a different study's subjective and objective assessments, severe burden was more frequently reported than moderate stress [20], and spouses were more understanding [21]. The sociodemographic characteristics of the families and the length of the patients' drug use have a significant impact on how much of a hardship the relatives are placed under [22]. The current study sought to determine the pattern of stress experienced by family caregivers of males undergoing alcoholism treatment at a de-addiction facility in India.

Materials and Methods

At the tertiary care centre in Ahmednagar a cross-sectional research was carried out. It is a care centre with many specialties. Patients willingly seek out therapy through self- or family-referral. The study protocol was approved by the institutional research committee. Data collection from the outpatient department (OPD) was done from June 2021 to May 2022 at tertiary care centre in Ahmednagar using a convenience sample approach. Both the patients and the caregivers taking part in the trial provided written informed permission. Patients and their carers who were seeking treatment for alcoholism made up the sample. The study included family caregivers who shared a home with the patients, were directly

involved in patient care for longer than a year in terms of treatment-related assistance or supervision, and were indirectly involved in general life care (shared kitchen, shared expenses, mutual social relationships, and household chores). When more than one caregiver was available, the research only included the most responsible caregiver (who was staying together longer and being involved in the care more, as agreed by a consensus among the patient and caregivers). According to the World Health Organization's tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10),[24] the patients were males who were at least 18 years old and had been diagnosed with alcohol dependence. They were currently receiving therapeutic intervention for management. Between two and five years were spent unwell in all. The exclusion criteria for the study's participation were any family member who currently had a serious physical or organic ailment or mental disability.

Sociodemographic, clinical, and information from the patient and caregiver's record files were gathered. A standard format detailing sociodemographic characteristics was established and standardised to collect sociodemographic information from selected individuals during interviews.

The Family Load Interview Schedule (FBIS)[25] was used to measure the degree and pattern of burden on the primary caregiver in order to understand the burden-related features of carers. It is a semi-structured interview schedule that covers six facets of life, including financial burden, disruption of daily routines, disturbance of leisure time, disruption of family relationships, impact on others' physical and emotional well-being. There are 24 elements in all, each of which is scored on a three-point scale (mild, moderate, and severe). Correlational validity and inter-rater reliability for all items are both 0.78 and 0.72, respectively. A final question evaluates the overall subjective load.

Statistic evaluation

The Statistical Package for the Social Sciences (SPSS) version 20.0 for Windows was used to analyze the data. By analyzing frequency, percentage, mean, and standard deviation from descriptive statistics (SD). To comprehend the relationship between the variables, a Pearson correlation was applied.

Results

The socio-demographic breakdown of the participants is shown in Table 1. The average age of those who struggled with drug abuse was 41.2 years, and a majority of them were still happily married. Only 15 percent of participants had a degree, while 35 percent had little to no formal education. The majority of the participants who were self-employed were from rural origins, albeit 35 % of them were from urban residential areas. Sixty-three percent of them were from nuclear households, and they typically supported their families financially.

Close family members who live with the dependent person and take care of all of their needs and requirements in day-to-day living are known as caregivers. 3.3% of them were widowed, while 93% of them were currently married. Caregivers are included in Table 2, and 75% of them were wives. 25 % of those who provided care were mothers or daughters of addicts. The family load was found to be high for carers in all six categories, as shown in Table 3. Financial burden had a mean score of 6.5 and a maximum score of 12, indicating a moderate level of burden. Disruption of regular family activities had a reported mean score of 6.34, disruption of family leisure had a mean score of 5.11 and a maximum score of 8, and disruption of family interaction had a mean score of 5.2 and a maximum score of 9, indicating a moderate to severe level of burden. Light stress was also indicated by the impacts on

both physical and mental health (1.3 and 1.1) respectively. In addition to the aforementioned domains, we found that the carers' subjective burden was quite high. According to Table 4, there was a positive correlation between the total number of loads and the length of the disease. That explains why the amount of load grows over time as drug duration increases. Additionally, research revealed a strong positive association between all of the sub [1] domains of load and financial burden. This shows that financial pressure increases all sorts of hardship among caretakers, or it can be the other way around.

Table 1: Socio demographic profile

Variable	Participant(n=30)		Percentage
Age	Mean±SD		41.2 ± 6.34
Maritalstatus	Unmarried	6	3
	Married	194	97
Education	Illiterate	24	12
	Primary	46	23
	Middle	10	5
	12^{th}	70	35
	Graduate	20	10.0
	Higher/professional	30	15
Occupation	Un employed	50	25
	Employed	150	75
Family type	Joint	75	37.5
	Nuclear	125	62.5
Residence	Urban	70	35
	Rural	100	50
	Semi-urban	30	15
SD: Standard deviation			

Table 2: Care givers relationship with the alcohol dependent patients

Variable		Number	Percentage
Relationship with patient	Wife	150	75
	Mother	25	12.5
	Daughter	25	12.5
Caregivers ‘occupation	Housewife	160	80
	Service	20	10
	Self-employed	20	10

Table 3

Variables	Level	Mean	SD
Financial burden	Moderate	6.5	1.21
Disruption of routine family activities	Moderate	6.34	2.23
Disruption of family leisure	Severe	5.11	1.23
Disruption of family interaction	Severe	5.20	1.25
Effecton physical health of others	Mild	1.34	1.45
Effecton mental health of others	Mild	1.12	1.67
Othe rburden	Mild	0.26	0.34
Subjective burden	Mild	1.45	0.67
SD: Standard deviation			

Table 4:Relationship between total duration of illness and sub-domains of burden

Sub-domains of burden	Routine family activities	Disruption of family leisure	Disruption of family interaction	Effect on physical health of others	Effect on mental health of others	Other burden	Subjective burden	Total duration of illness
Financial burden	0.67**	0.49*	0.46**	0.48*	0.54**	0.41*	0.55**	0.77**
Routine family activities	1	0.30*	0.44*	0.51**	0.54**	0.30*	0.45*	0.70**
Family leisure		1	0.94**	0.21	0.33	0.47*	0.40**	0.66**
Family interaction			1	0.33	0.33	0.51**	0.57**	0.72**
Physical health of ohers				1	0.99**	0.52**	0.39	0.67**
Mental health of others					1	0.591**	0.39	0.67**
Other burden						1	0.34*	0.69**
Subjective burden							1	0.63**
Total duration of illness								1

Discussion

200 patients that met the other inclusion and exclusion criteria as well as the ICD-10 criteria for "dependency" were included in this hospital-based cross-sectional investigation. The mean ages of the alcohol-dependent individuals and the persons who cared for them were 41.2 years and 38.59 years, respectively. The mean ages of patients and primary caregivers were determined to be 44.72 years and 41.17 years, respectively, by [26] in India. Sen *et al* research's team found in another study [22] that the majority of patients were aged 30-49 and the majority of carers were aged 30-39. All of the participants in our survey were Hindus, which may be explained by the fact that Muslims are the religion with the second-highest geographic presence, followed by Hinduism, and that alcohol consumption is prohibited in Islam. Ninety-six percent of the patients were married. In contrast to Malik *et al*. [27], who found that the majority of dependent patients were illiterate (61%) and whose findings were similar to ours in that 61% of the respondents had at least a primary level of education, 60 % of our patients had at least middle or higher education, and only 12% were illiterate. When the family structure was examined, it was shown that the majority of patients came from nuclear households. Our results were comparable to those of Mattoo *et al*. [26], who showed that maximum dependent patients came from nuclear families, and they differed from those of a prior research by Sen *et al*. [22] that revealed 60% of respondents were from joint/extended families.

This study lends credence to the widely held view that a strong family structure guards against drug misuse and other psychiatric morbidities. In this cultural perspective, husbands were often the main carers. Our study's finding that 93% of carers were spouses was in line with earlier research by Sen *et al*. [22], who discovered that 74% of carers were spouses, and Mattoo *et al*. [26], who discovered that 77.5% of primary caregivers were the wives of the substance-dependent individuals.

It was discovered that majority of the different family load locations had light burdens, followed by moderate and severe burdens. The primary carers' subjective burden was found to be extremely high, and interruption of regular family activities came next. The majority of Indian research have shown that primary carers have moderate to severe loads, particularly in the areas of subjective burden,[22] finances, interruption of normal activities, family leisure, and interpersonal relationships. [26,27] Therefore, the majority of the dependent patients were between the ages of 35 and 45, married, from rural backgrounds, nuclear families, with an average level of education, from the lower or lower middle socioeconomic class, and the majority of them were being cared for primarily by their spouses (housewives). A moderate to severe family strain affected the majority of main carers, particularly in areas like interruption of regular family activities, recreation, and interaction. The subjective load was also greater when the major carers were wives, the patients were from rural regions, and the nuclear family type was illiterate or uneducated.

Additionally, it was shown that the risk was higher if the family belonged to a lower socioeconomic class and increased if the carers were financially reliant on others (housewife/unemployed). Although they represented a variety of groups, the majority of the participants in the current study were from rural and semi-[1] urban regions. Family members, especially the woman, accept their husband's drinking issue as a result of cultural formation and individual acceptance, and they take full responsibility for the family and work to restructure it. [17]

As a result, they bear a more physical and psychological strain than the other family caregivers. Housewives and the jobless bore a heavier moderate to severe stress than carers who were employed [22]. Family stress was linked to patients' low socioeconomic level and rural residence [26]. Rural residents have few employment options, and as the majority of them lack advanced degrees and do not obtain well-paying positions, they tend to belong to bottom or lower middle social classes. The psychological and financial stress is increased by the poor financial status and scarce resources. If a person becomes dependent on alcohol and must spend a considerable portion of his income on getting alcohol and/or getting treatment, this exacerbates the problems and adds to the subjective and objective strain on the family. Similar to other studies, it was discovered that family burden sub-domains had a positive association with one another [26,28]. Contrary to a prior study[29] that claimed that the level of burden among the spouses of alcoholic dependents reduces over time, we discovered a positive significant link between the length of sickness and the degree of various categories of hardship. Her life happiness increases as she gains insight into the patient and acquires coping mechanisms. Our findings demonstrated that family members, including the wife, experienced an increase in stress across all domains as a result of subpar role performance and low social acceptability. One of the rare studies to examine the distribution of family burden among the primary carers of dependent patients was carried out in India, specifically in the state of Haryana. The intensity of family stress is correlated over time with family sociodemographic characteristics and the length of drug addiction and dependency cases. Preventive

and management measures must therefore be framed in a preferred multidimensional way against the backdrop of these results. The research did, however, include a few restrictions. It was only allowed at a tertiary care hospital. It might not adequately depict the distribution of sociodemographic factors among alcoholic patients and the people who care for them. Depending on how heavy the family load is on the community, it might not be relevant. There was no control group used for comparison, and the sample size was limited. Additionally, because this was a cross-sectional study, it was not possible to monitor the main caregivers who had a heavy load in the area of mental health to determine if they went on to acquire a psychiatric disorder in the future. In order to determine whether there is any correlation between caregivers' burden and level of motivation, the motivation of the primary participants was not evaluated. Therefore, more prospective studies involving more patients who are followed up for longer periods of time are required to be conducted in this context for a more thorough evaluation.

Conclusion

Families with low income in rural areas have been found to have a very high family burden, which is amplified in nuclear families. These results might offer some management suggestions as well as guidelines for this field's future research.

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