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Family Burden in The Patients of Alcohol Dependence Syndrome Attending the Psychiatry Department of Tertiary Hospital

Bibek Subedi[1], **Pradip Man Singh**[2]

[1]Department of Psychiatry, College of Medical Sciences and Teaching Hospital, Bharatpur, Chitwan, Nepal, [2]Department of Psychiatry, Nepal Medical College and Teaching Hospital, Kathmandu, Nepal.

ABSTRACT

Background

Substance abuse/dependence causes significant harm to self, family and society as a whole. The study of family burden in alcohol dependence assumes importance because the profile of the associated factors can both influence the outcome of the problem, and be useful in designing and planning interventions to help the families cope with alcohol dependence. The aim of the study is to measures the various aspects of burden on caregiver or family members of alcohol dependent patients.

Methods

A descriptive, cross-sectional, hospital-based study at Nepal Medical College and Teaching Hospital on 105 respondents (n=105) for 1 year (3rd October 2016 - 3rd September 2017) was carried at Attarkhel. Proforma, Family burden interview schedule (FBIS, Pai and Kapur) and Diagnostic Criteria for Research by the Division of Mental Health of the World Health Organization (WHO) as per Tenth Revision of International Classification of Diseases were tools used for data collection and the data was entered in MS-Excel and analyses was done by SPSS version 16.

Results

The subjective burden analysed found that spouse (59%) had more burden than non-spouse among caregivers. The burden was moderate among the female spouse and high among illiterate and unemployed ones.

Conclusions

This research suggests that there is moderate burden among the PCTs of the respondents and mainly spouse are the ones to be affected more. The increasing trend of alcohol consumption among males and females either literate or illiterate, employed or unemployed has a devastating role to the family as well as society.

Keywords: burden; primary caretaker; alcohol dependence syndrome.

Correspondence: Dr. Bibek Subedi, Department of Psychiatry, College of Medical Sciences and Teaching Hospital, Bharatpur, Nepal. Email: bibek5198subedi@gmail.com, Phone: +977-9861366265. **Article received**: 2025-03-16. **Article accepted**: 2025-08-14. **Article published**: 2025-09-15.

INTRODUCTION

A cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviour that once had greater value is defined as the alcohol dependence. Alcohol dependence syndrome and its relationship to behavioural and environmental factors has gained importance only lately.[2] The costs that families incur in terms of economic hardships, social isolation and psychological strain, are referred to as family burden.[3] The burden on families on account of substance abuse by a family member has begun to come into focus since the 1990s.[4] Hoenig and Hamilton studied subjective burden which includes the effects of the illness on finances and routine of the family, while the latter is defined as the extent to which family members are affected by objective burden.[5] A study from India using Family Burden Interview Schedule (FBIS) showed moderate to severe burden in all three groups. The study of family burden in alcohol dependence assumes importance because the profile of the associated factors can both influence the outcome of the problem, and be useful in designing and planning interventions to help the families cope with alcohol dependence. The objective of the study is to assess the burden experienced by primary care takers (PCTs) of patients with alcohol dependence syndrome.

METHODS

A cross-sectional study was carried out at Department of Psychiatry, Nepal Medical College and Teaching Hospital, Jorpati, Gokarneswor-8, Kathmandu, Nepal for 1 year (3rd October 2016 - 3rd September 2017) on a sample of 105 respondents (n=105). The ethical clearance for the study was approved by the Institutional Review Committee (IRC) of Nepal Medical College & Teaching Hospital (Ref No. 141-072/073). All consecutive cases who met the diagnostic criteria of ADS attending the psychiatry OPD and admitted patient in the ward or cases referred from any other department of Nepal Medical College and Teaching Hospital were included in the study. Inclusion Criteria: Sample of all cases of alcohol dependence syndrome. Exclusion Criteria: Those who refused to give family details, the patients and patient parties who do not give the informed consent, pregnancy & patients and PCTs with comorbid medical and surgical illness.

Pro forma: It is developed specifically to record the socio-demographic data and presenting complaints in verbation. Family burden interview schedule (FBIS, Pai and Kapur): It is a semi structured interview schedule comprising 24 items grouped under six areas. 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 source instrument was translated to Nepali language by two translators using standard methodology.[6] Diagnostic Criteria for Research by the Division of Mental Health of the World Health Organization (WHO) as per Tenth Revision of International Classification of Diseases -It deals with the mental and behavioral disorders and is mainly used for research purposes. It gives operational criteria for the diagnosis of mental disorders. The criteria are clearly defined and are specified in more detail.[1] The data was analyzed using SPSS version 16 and simple descriptive statistics (percentage, mean, SD) were analyzed. For association, chi-square test was applied. The level of significance was set at p-value< 0.05.

RESULTS

Table 1 reports descriptive study of study population. It shows the distribution of PCTs on the basis of age group, sex, occupation, marital status, educational status and relation to the patient. Most of the PCTs were of age group below 40 (72.4%), female leading the role of the PCTs (67.6%), employed and unemployed were almost equal, most were married (78.1%), literate (88.5%) were higher compared to illiterate (31.4%) and most of the PCT were spouse (59%) compared to non-spouse (41%).

Table 2 shows the correlation of sociodemographic features with caregiver burden. It shows the prevalence of moderate caregiver burden among spouse and non-spouse are 82.3% and 86% and and severe caregiver

Table 1. Sociodemographic characteristic of sample. (n=105)	
Sociodemographic status	**Frequency (%)**
Age	
<40	76(72.4)
40-65	29(27.6)
Sex	
Female	71(67.6)
Male	34(32.4)
Occupation	
Employed	53(50.5)
Unemployed	52(49.5)
Marital status	
Married	82(78.1)
Unmarried	23(21.9)
Educational status	
Illiterate	33(31.4)
Literate	72(68.6)
Relation	
Spouse	62(59)
Non-spouse	43(41)

burden among spouse and non-spouse 17.7% and 14%. It shows linear relationship between caregiver burden and relation with respondent (p-value>0.05). It shows the prevalence of severe burden in caregiver age group up to 40 is 8.3%, 40-65 age group is 18.4% and >65 age group is 20%. Moderate burden is high in age group up to 40 years (91.7%) but the relationship between age group and caregiver burden is not significant (p-value>0.05). It shows the prevalence of moderate burden in caregiver male is 84.8% and in caregiver female is 76.9% and male with higher rate of moderate burden (84.8%) and female with higher rate of severe burden (23.1%). However, there is no significant relationship between gender and caregiver burden (p-value>0.05). It shows prevalence of severe caregiver burden among literate which is 11.5% and in illiterate is 20.8% and moderate burden high among literate (88.5%). The relationship however is not significant (n=105, p-value>0.05). It shows almost equal moderate and severe burden in caregiver among married and unmarried respondents. The data shows linear relationship and is not significant (p-value>0.05). It shows caregiver burden is moderately high for urban respondents (85.5%),

Table 2. Correlation of Caregiver burden with socio-demographic characteristics. (n=105)				
Socio-demographic characteristics	**Caregiver Burden (%)**		**χ^2**	**p-value**
	Moderate	**Severe**		
Age				
<40	91.7	8.3	1.424	0.491
40-65	81.6	18.4		
>65	80	20		
Sex				
Male	84.8	15.2	0.519	0.471
Female	76.9	23.1		
Education				
Literate	88.5	11.5	1.643	0.2
Illiterate	79.2	20.8		
Marital status				
Married	83.7	16.3	0.915	0.659
Unmarried	83.8	16.2		
Domicile				
Urban	85.5	14.5	1.681	0.431
Semi-urban	100	0		
Rural	78.1	21.9		
Occupation				
Employed	90.2	9.8	2.981	0.084
Unemployed	77.8	22.2		
Ethnicity				
Brahmin-Chhetri	86.5	13.5		
Adibasi-Janjati	83.8	16.2		
Relation				
Spouse	82.3	17.7	0.269	0.604
Non-spouse	86	14		

almost all (100%) for semi-urban respondents. The data is not significant (p-value>0.05). It shows that there is moderate caregiver burden (90.2%) among employed respondents and the data is not significant (p-value>0.05). It shows almost equivalent caregiver burden among all ethnic groups, moderate caregiver burden among Brahmin-Chhetri and Adibasi-Janjati being 86.5% and 83.8%, severe care giver burden among Brahmin-Chhetri and Adibasi-Janjati is 13.5% and 16.2% respectively and the relationship is not significant (p-value>0.05).

Table 3 shows that there is burden in all categories of FBIS except effect on physical health of other family members and any other burden.

Table 4 shows that spouse has slightly higher subjective burden compared to non-spouse however

the data shows no significant relationship between subjective burden and relation of PCT to respondent.

Table 3. FBIS (Family Burden Interview Schedule). (n=105)	
Categories	**Mean±SD**
Effect on family routine	4.43±1.08
Effect on family leisure	3.83±1.12
Financial	5.37±1.25
Effect on family interaction	3.17±1.00
Effect on physical health of other family members	2.43±1.14
Effect on mental health of other family members	1.70±0.79
Any other burden	1.44±0.72
Subjective burden	22.37±4.96

Note: Mean represents the the mean value of the extent of burden perceived by the PCTs.

Table 4. Subjective burden in spouse and non-spouse. (n=105)			
Relation	**Frequency**	**Mean±SD**	**Standard Error Mean**
Spouse	62	22.84±4.90	0.62
Non-spouse	43	21.69±5.02	0.77

Note: Non-spouse includes father, mother, sibling and the first-degree relatives.

DISCUSSION

Alcohol dependence is a severe mental health problem which is associated with burden to patient and family members (PCTs) in health, social, financial and other aspects. Alcoholism is a devastating disease which can cause patient and family suffering.[7,8] Alcoholism is related to other addictive substances such as tobacco and illicit drugs.[9] A history of problem drinking appears to be a significant marker for behavioral disturbances in late life.[10] Childrens of alcoholic are subjected to an extremely disorganized milieu, negligent and abusive rearing, economic hardship and social isolation that accompanies attempt to hide disorder from friends, relatives and others.[11] Such impact becomes even more obvious in a developing country like Nepal. This aspect of the burden of alcohol use has received scant attention. Like many other societies, Nepali society is a society in transition. Changing roles, increased stress and alterations in lifestyle bring with them newer problems. Our study assessed the caregiver or PCTs burden among 105 subjects in the study associated with alcohol dependent subjects. The study's socio-demographic profiles and burden level (assessed through FBIS) in PCTs were compared with the similar study done in Nepal, India and western countries.

In this study, the distribution of respondents on the basis of age group were evaluated. Majority of cases were of age groups 40-65(72.4%) years followed by age group below 40 (22.9%) and the least being above 65 years (4.8%). Majority of alcohol dependence syndrome patients were of middle-aged group. A study done in Dharan[12] among 60 subjects in family burden in substance dependence syndrome showed that majority of ADS were more than thirty years old. Our study showed most of the PCTs were of age group below 40(76%). Burden was high among young adult age group. Our observations of the age group presentation of the caregiver of alcohol dependent subjects were in parallel to the majority of the studies done in Nepal and India and those included mainly the young adults. Our study showed total number of males was 92(87.6%) while female was 13(12.4%). Alcohol dependence is higher among males than compared to female. A study done in Dharan among 60 subjects in family burden in substance dependence syndrome showed that majority of subjects were male (80%) and female outnumbered male as PCT of the subject (n=31, 51.7%). In this study, female lead the role of PCT (71%). It shows female caregiver had more burden. 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.

A study done in Nepal[13] (n=18, 60%) and India (n=134, 67%) on the caregiver burden in alcohol dependence showed that most of respondents resided in urban areas. In this study, PCTs residing in urban area is higher (65.7%), followed by rural area (30.5%) and the least being semi-urban area (3.8%). The finding of urban dominance of PCTs of alcohol dependent subject is consistent with other studies. This is probably due to the rapid expansion of the city migrants from adjacent town due to urbanisation and for better facilities.

In our study, the PCT being employed (48.6%) and unemployed (51.4%) were almost equal. Unlike, similar study done in Dharan showed the subject and the PCT were unemployed whereas study done in India on caregiver burden in alcohol dependence syndrome showed that most of the subjects were employed (three-fourth of the subject). The unemployed PCT being slightly high suggest that unemployed were caregiving the respondents due to easy availability. Our finding contrasted the notion which consider a single person to be socio-cultural risk factor for alcohol dependence, as overall representations of married subjects (99%) dominated. Many other studies in Nepal found more subjects to be married. Our study showed most of the PCT were married (78.2%). This may be due to the fact and understanding in our society that marriage can solve the problem. Another reason for such finding may be because of early marriages and cohesive marital bond in Nepalese society. A study in India [14]showed that more than fifty percent of the subject and PCT were literate outnumbering the illiterate ones. Similarly, a study done in Dharan showed majority of subject (n=28, 93.3%) and PCT (n=40, 66.7%) were literate. In this study, illiteracy (50.5%) and literacy (49.5%) among alcohol dependent subjects were almost equal. However, among PCT, there was higher number of literate (68.6%) compared to illiterate (33%). Our study goes parallel to the majority of study conducted in India. This may be owing to the fact that literate people are more conscious and aware of health and health related condition and acts as a better caregiver. On the basis of ethnicity, our study showed the PCT belonging to the Adibasi- Janjati (64.8%) had higher preponderance compared to Brahmin-Chhetri (35.2%). The dependence pattern seemed high in Adibasi-Janjati group and it may be due to cultural influence. In this study, majority of the PCT were spouse (59%) compared to non-spouse (41%). It suggested that spouse of respondents were one with more burden than the non-spouse ones. A study done in India and western study showed that PCT were mainly spouse. The largest part of primary caregiving is provided by female relatives. Moreover, women are the most important treatment motivator of the subjects. Correlation of the various socio-demographic profile with caregiver burden was done and it was found that there was no significant relationship between caregiver burden and various parameter of socio-demographic profile. One study done in India[15] showed caregiver burden was significantly related with various parameter of socio-demographic profile which did not corroborate with our study. FBIS was the assessment tool for finding the severity of burden in 105 cases and it was found out that each category. i.e. financial, effect on family routine, effect on family leisure, effect on family interaction, effect on physical health of other family members, effect on mental health of other family members showed moderate burden. The subjective burden analysed found that spouse (59%) had more burden than non-spouse among caregivers. The subjective burden perceived by the spouse was 22.8±4.1 and the subjective burden experienced by the PCT was 22.9±4.9. The burden is higher in the spouse due to the close proximity of the spouse with the subject as they are the one who will be caregiving them most of the time. The burden in PCT was high in financial area followed by effect on family routine (unable to go to work, unable to help in household duties and disruption of activities in patient care) and least in any other burden excluding other areas of burden. The financial burden was more owing to substance and treatment expenditure.

Limitations

Among the limitations of this study was the small study sample size. So, generalization could not be made. As far as we know, there were no similar studies in Nepal on a large scale or national level, most studies in this area of interest are of small sample sizes. But, nevertheless, they still do highlight the issue. The primary caretakers were screened for the presence of a psychiatric disorder using a clinical interview and a formal assessment was not carried out. The psychological distress experienced by primary caretakers may have influenced their ratings of burden. Further investigations with a larger sample or even a nationwide study should be performed in order to evaluate the issues and ascertain the results in this paper.

CONCLUSIONS

This study suggests that there is moderate burden among the PCTs of the respondents and mainly spouse are the ones to be affected more. The increasing trend of alcohol consumption among males and females either literate or illiterate; employed or unemployed has a devastating role to the family as well as society. A national policy needs to be formulated aimed to create awareness about moderation of alcohol consumption, associated health consequences, impact on family and friends and work productivity. Alcohol dependence possesses problems not only on the individual users but also on the family and the community. The study of family burden in alcohol dependence assumes importance because the profile of the associated factors can both influence the outcome of the problem, and be useful in designing and planning interventions to help the families cope with alcohol dependence.

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