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Research Article

A Descriptive Study to Assess the Perceived Social Burden of Substance Abuse among Family Members of Drug Addicted Patients at Drug De-addiction Centre

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A B S T R A C T

Background: The study was conducted with the aim to assess the perceived social burden of substance abuse among family members of drug-addicted patients at drug de-addiction centre in Shri Maharaja Hari Singh Hospital of Kashmir (SMHS), Srinagar, Kashmir, India.

Methodology: Quantitative research approach in SMHS Hospital Srinagar, purposive sampling technique was used on 100 family members of drug-addicted patients. The obtained data was analysed by using descriptive and inferential statistics.

Result: The findings of the study revealed that the mean, median, standard deviation and mean percentage of burden score of family members is 90.58; 91; 7.54.; with maximum score 105 and minimum score 72, range 33 with mean percentage 75.48 respectively. The present study indicates that maximum of respondents 90 (90%) had severe burden, 10 (10%) had moderate burden. The Chi-square value shows that there is significant association between the burden score level and demographic variables [Gender (P=0.4), type of family (P=0.28) and relation with patient (P=0.000)].

Conclusion: Majority of the subjects whose relatives were seeking treatment at drug de-addiction centre experienced severe burden, as they were less social. Both genders experienced moderate to severe burden but females had more burden than males. There was significant association of the level of perceived social burden with selected demographic variables such as gender, type of family and relation with patient. No significant association was found with age, education, income, occupation and residence.

Keywords: Substance abuse, Social burden, De-addiction Centre, Family Member

Introduction

Alcohol and drug use disorders have devastating physical, mental, and socio-economic consequences not only for patients but also for their families. It is a critical public health concern for which the global burden far exceeds the difficulties experienced by many of the 250 million drug users[1], or the two billion alcoholic drinkers[2] worldwide. Their illness substantially affects the quality of life of other family members, including financial security, mental health, social networks, and productivity. The cost approaches 2 per cent of the gross domestic product of some index countries.[3] Family involvement with the disease of addiction was self-evident to social workers who, in the early 20th century, did their work in clients' homes and could see directly how families function[4], but has only recently received proper scientific attention. Psychiatric research on caregiving has increasingly recognized the price paid by families of individuals with mental health problems and their contribution to the care process.[5] However, the analysis has traditionally been limited to relatives of individuals with mental disorders like schizophrenia, bipolar disease, or dementia, and investigations on drug and alcohol use have been slowly following the path. The delay is perhaps due to a difficult progression from focusing on the role of the family in generating or exacerbating the drug user's problems, through identifying family members as recipients of care, to learning what they can offer to the management of addiction. Still today, primary challenges remain the broadening of the substance abuse treatment attention from the individual to the family and its active participation in the recovery process. In this issue, Mattoo SK[6] conducted a cross-sectional study at Post Graduate Institute of Medical Education and Research (PGIMER) with ICD-10 diagnosed substance dependence subjects and their family caregivers attending a de-addiction centre at a multispecialty teaching hospital in north India. Almost all (95-100%) caregivers reported a moderate or severe burden, which indicates the gravity of the situation and the need for further work in this area. Compared to the opioid dependence and alcohol opioid dependence groups, the alcohol dependence group was older (44.72 ± 8.95 year vs. 28.12 ± 7.06 and 32.15 ± 9.13 year, respectively, $P < 0.01$), was more often working (82.5 vs. 47.5 and 37.5, respectively, $P < 0.01$), with income of > 6000 per month (67.5 vs. 15 and 27.5%, respectively, $P < 0.001$), and less often with no income (12.5 vs. 55 and 67.5%, respectively, $P < 0.001$). They were mostly married (95 vs. 47.5 and 62.5%, respectively, $P < 0.01$). The three groups were comparable for education, religion, family type, family size and rural-urban location (Table I). On Post-hoc analysis with Bonferroni' correction, patients with alcohol dependence were significantly older than in opioid dependence group (44.72 ± 8.95 vs. 28.12 ± 7.06 year, $P<0.001$), and alcohol opioid dependence group (44.72 ± 8.95 vs. 32.15 ± 9.13 year, $P<0.001$). If compared across cultural boundaries and socio-economic conditions, or with different psychiatric diseases.[5] In particular, the finding that living in a rural environment, together with earning a lower income, was associated with greater family burden offers important elements of reflection. As the level of education of caregivers or patients did not play a significant role in the perceived burden, we may assume that access to treatment and social support are important components to enable coping with the burden of a chronic disease. Indeed, beyond the initial evidence of how having a family member with an alcohol or drug problem affects family functioning and leads to increased risk of developing patterns of physical and behavioural problems, we observe a reduction of medical cost and utilization by the family when that individual receives treatment for his problems.[3] In addition, international families of patients with chronic psycho-behavioural conditions seem to give increasing significance to the personal and political benefits of organizing to not only learn and understand how to cope with the problem but also to help foster a social response. It has been demonstrated that in the daily routine of living with substance dependence and other chronic psychiatric illnesses, lack of perceived social support by family caregivers is an important predictor of subjective caregiver burden if external support from the family is lacking, and of objective burden if other family members are of little help.[8] It is important to keep in mind the complex role that families play in substance dependence. The assistance they provide is multifaceted, including direct care, financial assistance, and management of illness symptoms, as well as helping directly their relatives' engagement and retention in treatment. As they can be a source of help to the treatment process, they also must manage the consequences of the addictive behaviour. Family members are concerned about the substance abuse behaviour of the individual, but they also have their own problems. At times, complementary or mirroring problems may crystalize the relationship into a co-dependent dimension, where the 'non-ill' member becomes overly concerned with the difficulties of the other, and renounces to his/her own wants and needs. Of course, this concept can lead to the risk of pathologizing otherwise normal caring functions, particularly those that have to do with empathy and self-sacrifice. In a potentially highly unstable 'role play', members often must change their conventional family roles or add new, often-inappropriate functions in order to adapt to the unpredictable, unreliable and sometimes demanding behaviour of the substance abuser. The individual typically engages with searching or using substances most of the time and is often incapacitated by the effects of alcohol or drugs, which leaves him/her unable

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to fulfil any responsibility in the family. Vacant roles may be redistributed and some family members, especially children, might have to bear excessive responsibilities. To further complicate the picture, caregivers or other burdened members of the family often do not know how to ask for help, or refuse to do so because of shame and fear of social stigma[9]. The effects of the burden often extend beyond the nuclear family. Extended family members may share feelings of concern, fear, anger, embarrassment, or guilt; they may wish to ignore or defend from the individual abusing substances. Furthermore, the effects on families may continue through generations. Trans-generational effects of substance abuse may have a negative impact on role modelling and concepts of normative behaviour, which damages the relationships between generations and continues to influence family functioning well beyond the life of the 'sick' member[10], especially among those cultures where the extended family is an important reference point. Thus, providing services to the whole family can improve treatment effectiveness and contribute to social prevention and cost containment, as in families with alcohol or substance abuse single members often are connected not just to each other but also to any of a number of public agencies, such as social services, criminal justice, or child protective services. Although issues of caregiver burden are receiving increased attention, there is still a strong need for studies on the burden of alcohol and drug use, in particular investigations based on large sample sizes and control groups. Given the fact that primary caregivers represent a diverse group of relationships, future research should also determine if there are differences related to specific types of relationships and roles in the family. More epidemiological and longitudinal studies and studies from different cultures are needed to gain a better understanding of generic and specific factors that influence the relationship between family and mental health. Significant challenges concern both the study of care giving, and clinical practice and health policy. In research, further study on caregivers' ways of coping should identify effective strategies and focus on resources more than deficits. The estimate of financial burden will face the complexity of calculating immaterial costs and assessing the impact of service structures on burden. Quality of findings could be enhanced by further improving conceptual clarity and by the agreement on a few standard instruments for the measurement of caregiver burden to facilitate comparison. On the practical level, strategies to improve communication between families and health providers can be better developed if primary care physicians receive adequate training to operate a much-needed function of substance abuse screening and routine management.[11] Finally, an active involvement of families in the therapeutic process and the correct response to their needs can only be fully achieved with a transition from an acute model of brief treatment of alcohol and drug use problems, to a more comprehensive chronic care model, assigning equal importance to family members and the individual in both treatment and continuing care phases.

Objectives

- To assess the perceived social burden of substance abuse among family members of drug addicted patients
- To find the association between social burden scores of substance abuse among family members of drug addicted patients with selected demographic variables (age, gender, education, income, type of family, residence and relationship with patient)

Hypothesis

H_1: There is significant social burden of substance abuse among family members of drug-addicted patient at 0.05 level of significance.

H_2: There is significant association between social burden scores of substance abuse among family members of drug-addicted patients with selected demographic variables at 0.05 level of significance.

Methodology

Research methodology is a way to systematically solve the research problem. Research methods are the techniques used by the researcher to structure a study, gather and analyse the information relevant to the research questions. The research methodology includes research approach, research design, study setting and sampling technique, data collection method, development of the tool, description of the tool and data analysis. The present study aims to assess the perceived social burden of substance abuse among family members of the drug-addicted patients at drug de-addiction centre SMHS hospital Srinagar Kashmir. The research methodology organizes all the component of the study, providing the overall framework for availing valid answer to the sub problems that have been stated.

Research Approach

A quantitative approach is used to accomplish the objectives of the present study, and intended to gather data concerning social burden of substance abuse. It describes the situations, as they exist in the world and provides an accurate account of characteristics of particular sample, individuals, and situations. The outcome of quantitative descriptive research provides a basis for future research.

Research Design

The research design used for the present study was non-experimental descriptive design. The descriptive design was selected since it aided in attaining first-hand information and enhanced obtaining accurate and meaningful information data.

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Variables

The present study aims to assess the perceived social burden of substance abuse among family members of the drug-addicted patients at drug de-addiction centre SMHS hospital, Srinagar, Kashmir, India. The selected variables under the study were:

Research Variables

The research variables of the present study were the perceived social burden of substance abuse among family members of the drug-addicted patients at drug de-addiction centre SMHS hospital Srinagar Kashmir.

Setting

The setting of the present study was "Drug De-addiction Centre", a unit of Government Psychiatric Disease Hospital (IMHANS), in Srinagar (J&K). It is a three-storey building having 50-bed strength, was established in 2011 in the campus of SMHS Hospital. People from all corners of the valley avail its services for the treatment of substance abuse and other psychiatric disorders and it is utilized by medical and nursing students for their clinical experience. The hospital was selected for the present study because it is the largest drug de-addiction centre in the valley and has all the needed facilities. The study was conducted in drug de-addiction wards, OST, OPD and causality. There are total 35 rooms including a big recreational hall. At the time of data collection, the hospital received 150-200 Government patients in its Out Patient Department (OPD) and 3-4 patients were admitted daily with average 2-3 discharges every day.

Sample & Sampling Process

In this study sample consisted of 100 family members whose relatives were admitted, attending OPD and OST from 10 March 2017 to 10 April 2017 at drug de-addiction centre SMHS hospital, Srinagar, Kashmir, India and who met the inclusion criteria.

Sampling Technique

In this study, purposive sampling technique was adopted and it is referred to as judgemental sampling, which involves the conscious selection by the investigator based on accessibility. Family members whose relatives were admitted, attending OPD and OST at Drug de-addiction centre SMHS hospital were selected purposively by the researcher.

Result

Analysis and interpretation of the data were based on objectives of the study and the research hypothesis, using descriptive (frequency, percentage, mean, median, SD) & inferential statistics (paired "t" test & chi-square test).

Before analysis the results following null hypothesis were framed so that these can be proved statistically

H_{01}: There is no significant social burden of substance abuse among family members of drug-addicted patient at 0.05 level of significance.

H_{02}: There is no significant association between social burden scores of substance abuse among family members of drug-addicted patients with selected demographic variables at 0.05 level of significance.

Table 1.Frequency and percentage distribution of subjects according to their age (N=100)

Age (Years)	Frequency	Percentage (%)
Less than 15 years	2.0	2.0
15-30 years	18.0	18.0
31-45years	10.0	10.0
Above 45years	70.0	70.0
Total	100.0	100.0

The data presented in Table 1, reveals that maximum number of subjects 70 (70%) were in age group of above 45 years, 18 (18%) subjects were between 15-30 years, 10 (10%) subjects were between 31-45 years of age and 2 (2%) of the subjects in this study belonged to age group below 15 years.

Table 2.Percentage and Distribution of subjects according to gender (N=100)

Gender	Frequency	Percentage (%)
Male	33.0	33.0
Female	67.0	67.0
Total	100.0	100.0

The data in the Table 2 depicts that majority of the subjects that is 67 (67%) were females and only 33 (33%) of them were males as per the sample.

Table 3.Frequency and percentage distribution of subjects according to their education (N=100)

Education	Frequency	Percentage (%)
Illiterate	2.0	2.0
Primary	18.0	18.0
Up to high school	10.0	10.0
Graduation and above	70.0	70.0
Total	100.0	100.0

The data presented in Table 3, reveals that maximum no of subjects 72 (72%) were illiterate, 21 (21%) subjects were educated up to high school, 5 (5%) subjects were graduates and above and 2(2%) were educated up to primary school.

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Table 4.Frequency and Percentage distribution of Study subjects by their Occupation (N=100)

Demo-graphic Variable	Category	Freq-uency	Percentage (%)
Occup-ation	Government Employee	10.0	10.0
	Private Employee	1.0	1.0
	Any other	-	-
	Business	18.0	18.0
	Labourer	4.0	4.0
	Driver	3.0	3.0
	House Maker	63.0	63.0
	Student	1.0	1.0
	Total	100.0	100.0

The data in the Table 4, reveals that 89 (89%) of subjects belonged to any other category of occupation i.e. business 18 (18%) labourer 4 (4%), driver 3 (3%), house maker 63 (63%), and studet 1 (1%), 10 (10%) subjects were government employees and only 1 (1%) was private employee.

Table 5.Frequency and Percentage Distribution of subjects according to Income (N=100)

Income	Frequency	Percentage (%)
Less than 5000	11.0	11.0
5000-1000	22.0	22.0
10000-15000	27.0	27
Above 15000	40.0	40.0
Total	100.0	100.0

The data in the Table 5, reveals that 40 (40%) of subjects had monthly income above 15000 income, 27 (27%) subjects had monthly income between 10000-15000, 22 (22%) subjects had monthly income between 5000-10000 and 11 (11%) subjects had monthly income below 5000.

Table 6.Frequency and Percentage Distribution of subjects according to their type of family (N=100)

Type of Family	Frequency	Percentage (%)
Joint family	78.0	78.0
Nuclear family	22.0	22.0
Extended family	0.0	0.0
Total	100.0	100.0

The data presented in Table 6, reveals that maximum number of subjects 78 (78%) belonged to joint family and 22 (22%) subjects belonged to nuclear family and none of the subjects belonged to extended family.

Table 7.Frequency and Percentage Distribution of subjects according to Area of living (N=100)

Area of living	Frequency	Percentage (%)
Urban	23.0	38.0
Rural	37.0	62.0
Total	100.0	100.0

The data presented in Table 7, reveals that maximum number of subjects 71 (71%) belonged to urban area and 29 (29%) subjects were from rural area.

Table 8.Frequency and percentage distribution of subjects according to relation with patient (N=100)

Relation with Patient	Frequency	Percentage (%)
Father	27.0	27
Mother	36.0	36
Wife	28.0	28
Any other	9.0	10
Grand mother	1.0	1
Brother	5.0	5
Sister	3.0	3
Total	100.0	100

The data presented in Table 8, depicts that 27 (27%) subjects were fathers, 36 (36%) subjects were mothers, 27 (27%) subjects were wives and 10 (10%) belonged to any other category i.e. 5 (5%) subjects were brothers, 3 (3%) subjects were sisters and 1 (1%) were grandmother.

Table 9.Mean, Median, standard deviation, maximum possible and mean Percentage of Perceived social Burden among subjects whose family members were seeking treatment drug de-addiction centre (N=100)

	Mean	Med.	S.D.	Max.	Min.	Range	Mean %
Burden Score	90.55	91	7.55	105	72	33	75.46

The data presented in Table 9, depicts that mean burden score was 90.58, standard deviation was 7.54, median was 91, maximum possible score was 105 and mean percentage was 75.48. This shows that the subjects whose family members were seeking treatment at drug de-addiction centre experienced burden. This shows that our research hypothesis 1 has been accepted.

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Table 10.Frequency and Percentage Distribution of level of Social Burden among study subjects (N=100)

Category score	Freq. (f)	Percentage (%)
Mild Burden (1-40)	0.0	0.0%
Moderate burden (41-80)	10.0	10.0%
Mild Burden (81-120)	90.0	90.0%

Table 11.Association of the level of Perceived Social Burden with selected Demographic Variables (N=100)

Demographic Data					Association with Burden Score				
Variables	Sub items	Mild Burden	Moderate Burden	Severe Burden	Chi Test	P value	df	Table Value	Result
Age (Years)	Less than 15 Year	0	0	2	1.517	0.678	6	12.59	Not Significant
	15-30	0	2	16					
	31-45	0	0	10					
	Above 45	0	8	62					
Gender	Male	0	6	26	4.00	0.4	2	5.9	Significant
	Female	0	4	64					
Education	Illiterate	0	4	68	6.8	0.33	6	12.59	Not Significant
	Primary	0	0	2					
	Up to high school	0	5	16					
	Graduation and above	0	1	4					
Occupation	Govt. Employee	0	1	9	11.07	0.52	12	21.02	Not Significant
	Private employee	0	1	0					
	Business	0	3	15					
	Labourer	0	0	4					
	Driver	0	0	3					
	House maker	0	5	58					
	Student	0	0	1					
Monthly Income	Less than 5000	0	0	11	4.12	0.65	6	12.59	Not Significant
	5000-10,000	0	1	21					
	10,000- 15,000	0	5	22					
	Above 15,000	0	4	36					
Type of Family	Nuclear family	0	5	73	5.07	0.28	4	9.4	Significant
	Joint family	0	5	17					
	Extended family	0	0	0					
Residence	Rural	0	1	28	1.95	0.38	2	5.99	Not Significant
	Urban	0	9	62					
Relationship with Patient	Father	0	2	25	29.97	0.000	10	18.30	Significant
	Mother	0	1	35					
	Wife	0	3	25					
	Grand mother	0	0	1					
	Brother	0	4	1					
	Sister	0	0	3					

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The data prevented in the Table 10 in the present study reveals that majority of the subjects 90 (90.0%) severe burden, 10 (10%) subjects had moderate burden and 0 (0%) subjects had mild burden.

The data represented in Table 11 shows that the association between the level of social burden score and socio demographic variable. Based on the second objective Chi-square test used to associate the level of social burden with selected demographic variables. The chi-square value shows that there is significant association between the score level and demographic variables (Gender, type of family and relation with patient). There is no significant association between the level of scores and other demographic variables (age, education, occupation, monthly income, and residence). The calculated chi-square values were less than the table value at the 0.05 level of significance.

Therefore the null hypothesis (H03) which states there is no significant association between social burden scores with selected demographical variables i.e. Age, gender, education, income, occupation, type of family, residence and relation with patient at $p \leq 0.05$ level of significance is partially accepted and partially rejected. It is partially accepted for age, education, occupation, monthly income, and residence and partially rejected for gender, education, type of family and relation with patient.

Discussion

The findings of the study revealed that the mean, median, standard deviation and mean percentage of burden score of family members is 90.58; 91; 7.54.; with maximum score 105 and minimum score 72, range 33 with mean percentage 75.48 respectively. The present study indicates that maximum of respondents 90 (90%) had severe burden, 10 (10%) had moderate burden.

The present result was supported by the findings of a descriptive Study conducted by Mattoo SK A cross-sectional study was conducted 120 at Post -Graduate Institute of Medical Education and Research (PGIMER) with ICD-10 diagnosed substance dependence subjects and their family caregivers attending a de-addiction centre at a multispecialty teaching hospital in north India. Almost all (95-100%) caregivers reported a moderate or severe burden, which indicates the gravity of the situation and the need for further work in this area.

The findings of this study showed that the females had severe burden with mean 93.65 and mean percentage 77.6 and males had severe burden with mean 89.19 and mean percentage 74.3. This shows that females experienced more burden than males.

The present study findings are similar to the findings of a descriptive study conducted by Ray G. The burden is more often related to disruptive activities of the substance dependent person, and financial difficulties due to loss of income and/or diversion of funds to substance dependence. The families of alcoholics, specially the spouses, have increased risk of stressful life events, medical and psychiatric disorders, and greater use of medical care service.

The association between the burden scores with the selected socio-demographic variables was computed using Chi-square test. The present study indicates that significant association was found between the socio-demographic variable age, gender, educational qualification, occupation, and relation with patient of family members with their burden scores ($p \leq 0.05$), i.e. chi-square calculated > chi-square tabulated and no association was found between the socio demographic variable type of family, monthly income and residence of family members with their scores ($p \leq 0.05$), i.e. chi-square calculated < chi-square tabulated.

The present study was supported by findings of study conducted by Mattoo SK on comparing the demographic and clinical variables of subjects (N=120) with severe vs moderate subjective or objective burden, higher proportion of rural subjects reported severe subjective burden (61.53 vs. 39.24%, $P < 0.05$) compared to urban subjects. When similar comparison was made for various areas of burden, significantly higher burden was seen in unemployed subjects in the areas of financial burden (13.20 vs. 2.98, $P < 0.05$), disruption of family routine (54.71 vs. 31.34%, $P < 0.05$) and disruption of family interaction (20.75 vs. 10.44%, $P < 0.05$) compared to employed subjects. Higher proportion of rural subjects reported moderate-severe burden in the effect on physical health of family members (42.59 vs. 24.62%, P=0.05) compared to urban subjects.

Nursing Implications

Implications in Nursing Education

Nurses are the ones who are with the patient for a longer time than any other health personnel are. When the caregivers (family members) are burdened, they cannot verbalize their feelings of anxiety, tension, and frustration. So a nurse educator, need to contribute to the existing body of nursing knowledge about the needs of psychological and emotional support to care givers of drug addicts to facilitate a more holistic approach to meet both the needs of drug addicted patients and their family members.

- Nurses need to be taught about concepts such as comprehensive nursing care and family participation and more emphasis need to be given family involvement in rehabilitation programme
- Service education programme need to be emphasized to upgrade the knowledge of the nurses about factors causing burden, which may help to plan effective care

Other family members to be encouraged to relieve pressure on the primary care giver.

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Implications in Nursing Practice

Nurses have a unique role in providing comprehensive holistic care to critically ill sick and their families. Understanding the level of burden and coping strategies, can act as reference for nurses in planning appropriate interventions to minimize the burden level.

- Nurses need to help family members are adjusted to environment of drug de-addiction centre by giving information and proper explanations throughout the patient's stay. Such information should include orientation of family about the condition of patient
- Nurses need to be very active and anticipate the psychological burden on family members, by recognizing and attempting to meet these information needs and help to perceive their needs in way that is more realistic. This would provide useful information for planning individualized and family care and counselling aimed at enhancing better health outcomes of family members
- Nurses need to help the family member by telling them to set aside time for self-aid the caregiver in identifying those that bring them peace and relaxation.

Implications in Nursing Administration

Nurses are challenged to play the role of efficient administrators as well as practitioners. Administration in both private and government sectors should take initiative actions to update the knowledge of health personnel regarding burden experienced by family members in order to help them to cope with stressful situation.

- The nurse administrator need to organize and implement ongoing education and in-service program for nurses working with substance abuse patients and their families to gain adequate Knowledge and development of positive attitude and to provide adequate counselling and guidance to families in order to promote their coping strategies
- Nursing conferences, group discussions need to be conducted by the administrators periodically regarding substance abuse and improvement of de-addiction services for patients and their families
- The nurse administrator need to organize stress management programs for families whose relatives are seeking treatment at drug de-addiction centre
- The nurse administrator can provide adequate allocation of budget and manpower to implement effective counselling sessions to help the family members of drug addicted patients to become confident to meet the needs of self and patients and to cope with the stressful situation. The family member can also be referred to community resources or financial aid if necessary

Implications in Nursing Research

The importance of research in nursing is to build the body of knowledge. The findings of the present study serve as the basis for the professionals and students to conduct further studies.

- Nursing research can be done in the area of perceived social burden to identify sources of burden among family members of substance abuse patients during their stay at drug de-addiction centre. The family member with substance abuse disorder, creates unanticipated crises, alters family patterns in ways that leads to social burden and stigma
- Research can help the nurses to develop confidence as well as faith in family members and to develop constructive methods among them to reduce the burden
- Future research studies can make comparisons of the variables in families at various stages of development with other chronic childhood conditions. The purpose of subsequent research will be to develop family Health Nursing Intervention Strategies

Limitations

- The study was conducted only on 100 family members, which imposed limits in generalization of findings
- The study was limited only to specific dimensions of perceived social burden of family members of drug-addicted patients at drug de-addiction centre.

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Conflict of Interest: None

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