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A Study On The Caregivers Of Alcohol Dependent Patients Getting Treatment In De-Addiction Centre

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ABSTRACT
Alcoholism remains a serious threat on a global level, it is defined as ''family disease'' as it not only affects the individual who is being addicted to alcohol but largely affects on the family of the addicted person and their caregivers. This research would enunciate the effect of alcoholic patient on their caregivers and their challenges. The mixed method used with questionnaire and In-depth interview Guide. Data was collected form the primary caregivers of the alcohol dependent patients getting treatment in de-addiction centre. The illness adversely affects the individual as well as the caregivers in terms of physical, emotional, and financial distress, and social and occupational dysfunction. A alcohol dependent person in the family affects almost all aspects of family life, e.g., interpersonal and social relationships, leisure time activities, and finances. Alcohol dependence invariably increases conflicts, negatively affects the caregivers, and burdens them. The psychological and behavioural impact on the caregivers of alcoholic patient is often far greater than any of the individual in the family. Thus, this research suggests social work institutes and social wokers to concentrate largley and enhance working with the caregivers of alcohol dependent person to provide professional care, and suggets the de-addiction centres to work with the family memebers of the alcohlic dependents who get treatment in the de-addiciton centres.

Key words: *Alcohol dependent, Family disease, Caregivers, De-addiciton centres, Social work institutes, Social wokers.*

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I. Introduction and Review of literature

"The mentality and behaviour of drug addicts and alcoholics is wholly irrational until you understand that they are completely powerless over their addiction and unless they have structured help, they have no hope."
- Russell Brand

Alcoholism intrinsically remains as a serious, potential threat. According to the variability of drinking, all alcoholics pass through identifiable stages and the disease arrays in larger health issues related context which has variety of aspects, especially alcohol dependence in terms of alcohol consumption. Alcoholism has been one of the central themes of important problems in terms of global concern. The drastic impact of alcohol not only disturbs the physical health of an individual, but also additionally affects the people who are in and around their surroundings.

Researches have shown that men make up a large proportion of the alcohol consuming population in India that keeps increasing persistently with the passing of time. They may hugely consume alcohol to relieve from themselves from all sorts of negative and psychological distresses, including positive stress and negative stress, but the problem is that consumption of alcohol to relieve stress may lead to further social, emotional and physical problems. The magnitude of the problems becomes an added source of stress, and it leads to further decrease of a person's self-esteem and confidence **(Krishnaswamy, 2011)**

Family is the key resource for providing care to patients, including those with alcohol dependence in India. Person with alcohol dependence affects almost every (personal, social, and psychological) aspects of family life. This leads to troubles, difficulty or undesirable procedures which impact on family members and causes gigantic burden on family caregivers. Family plays a key role in the care of patients with alcohol dependence. This is especially very true in India because of various factors like the tradition of interdependence, the concern for 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. A nationwide Indian study on alcohol and drug abuse by Sarkar et al. estimated the prevalence of alcohol use as 21.4%. A study from southern rural India showed that 14.2% of the population surveyed had hazardous alcohol use on the Alcohol Use Disorder Identification Test (AUDIT). Another study from the tertiary care hospital at a rural district of Southern India reported that 17.6% of admitted patients had hazardous alcohol use.

The De-addiction centres are the major contributors to addiction treatment and rehabilitation. Ministry of Social Justice and Empowerment (MSJE) has adopted many strategies to deal with the problems of alcoholics in India.

II. Mental Health Act

The earlier law (Mental Health Act [MHA] 1987) did not specifically provide a definition of mental illness. MHA, 1987, defined a "mentally ill person" as "a person who is in need of treatment by reason of any mental disorder, other than mental retardation." Substance use disorder (SUD) was not specifically mentioned anywhere else, except in Chapter III, where MHA, 1987, obligated the government to set up separate psychiatric hospitals or psychiatric nursing homes for "those who are addicted to alcohol or other drugs which lead to behavioural changes in a person."

The current act, MHCA 2017, has purportedly included SUD in the definition of mental illness itself. However, the exact phraseology used in the definition gives rise to some ambiguities, which unfortunately have not been clarified elsewhere in the Act. Section 1(s) mentions "mental conditions associated with the abuse of alcohol and drugs," which purportedly includes SUD within the ambit of mental illness. The use of the term "abuse" is, however, ambiguous. Does the Act refer to the term "abuse" as was defined in the Diagnostic and Statistical Manual (DSM), version-IV. The current version of DSM **(DSM-5)** has abolished this term and clubbed different diagnoses in the earlier **DSM-IV** (i.e., "abuse" and "dependence") under a single entity "Substance Use Disorder." The current version of International Classification of Diseases (ICD) of the World Health Organization **(WHO),** version 10 (and the most recent, ICD-11) too, does not have any diagnostic category termed "abuse" If the term "abuse" has been used in the Act as a lay, nontechnical, non-diagnostic term, then this would constitute offensive, pejorative, and stigmatizing language (something the Act purports to address, ironically). The Oxford Dictionary defines "abuse" as to "use (something) to bad effect or for a bad purpose." If applied to SUD, this conveys more of a moralistic and judgmental position, which should be avoided in a law that deals with patients suffering from SUD. **(Ravindra Rao, 2019)**

III. Caregivers

The family caregivers are those who provide care to other family members who need supervision or assistance in illness or disability or those who provide unpaid care to the family members with needs. An illness adversely affects the individual as well as those around in terms of physical, emotional, and financial distress, and social and occupational dysfunction. This leads to problems, difficulties or adverse events which impact the lives of the significant others. This adverse impact has been described as burden. Burden is said to be largely determined by family environment in terms of coping styles of different family members and their tolerance of the patients' aberrant behaviour. 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.

Family is the key resource in the care of patients including those with mental illness in India. This has been attributed to the Indian tradition of inter-dependence, and the concern of close relatives in adversity, as also to the paucity of mental health professionals. The family caregivers are those who provide care to other family members who need supervision or assistance in illness or disability or those who provide unpaid care to the family members with special needs. **(Avasthi, 2010)**

A substance dependent person in the family affects almost all aspects of family life, e.g., interpersonal and social relationships, leisure time activities, and finances. Substance dependence invariably increases conflicts, negatively affects family members, and burdens the families. The psychological and behavioural impact on others is often far greater than on the substance dependent family member. Yet, because of the historical emphasis on substance dependence as an individual's problem, the study of family's problems has been relatively neglected. Consequently, systematic research on substance dependence related burden among the family members is very limited **(Surendra Kumar Mattoo, 2013).**

IV. History

History of Alcoholism in India

Alcohol usage has been a wedge issue of incredible uncertainty all through the rich and long history of the Indian subcontinent. The practices and states of mind about liquor use in India are extremely perplexing, conflicting and convoluted in light of the wide range of impacts in history. The advancement of liquor consuming and established system in India can be isolated into four expansive chronicled periods (time of composing records), starting with the Vedic time (ca. 1500- 700 BCE- Before Common Era). From 700 BCE to 1100 CE- Conformitee European, "Reinterpretation and Synthesis" is the season of the rise of Buddhism and Jainism, with some new enemy of liquor principles, and additionally post-Vedic improvements in the Hindu customs and academic composition. The works of the eminent medicinal professionals, Charaka and Susruta,

included new lines of thought, including continuations for "direct liquor utilize." The Period of Islamic Influence (1100-1800 CE), including the Mughal time from the 1520s to 1800, showed an unpredictable transaction across the board liquor utilize, competing with the reasonable Quranic restriction to liquor utilization. The fourth time frame (1800 to the present) incorporates the profound impact of the British frontier administer and the ongoing 50 years of Indian autonomy, beginning in 1947. The inconsistencies and ambiguities with the board liquor use in a few parts of society, including the high status standing of warriors/rulers (Kshatriyas), versus preclusions and judgment of liquor utilize, particularly for the Brahmin (researcher minister) position, have created liquor utilize designs that incorporate continuous high-hazard, substantial and risky drinking. The on-going powerful increments in liquor utilization in numerous segments of the general Indian populace, combined with the solid proof of the role of liquor in the spread of HIV/STI diseases and other well-being dangers, point to the requirement for itemized comprehension of the intricate crosscurrents rising up out of the previous history of liquor utilize and maltreatments in India. India is a tremendous subcontinent and the drinking propensities shift incredibly between the diverse states. It is in this manner fantastic to portray a solitary drinking society for the entire of India. The individuals who live in the south-western territory of 10 Kerala are the heaviest consumers. Individuals who live in this state drink a normal of 8 litres per capita, and this is four times the measure of whatever is left of India. Different regions of the mainland where individuals tend to drink moderately intense incorporate Haryana and Punjab. In a few sections of India, there is not really any drinking society to talk about – in a portion of these spots, liquor is prohibited totally. As of late, there has been a detectable ascent in the quantity of urban people who guarantee to use liquor as a way to unwind. Regardless, it is mostly poor people and the individuals who live in rustic zones that are the most noteworthy customers of liquor. It is trusted that as meagre as 5% of liquor purchasers are female – in spite of the fact that this figure is higher in a few states and very eminent in a bigger setting.

Transition Period

The British colonial era brought about a rapid social change of attitude towards drinking. Prior to colonization, only the Brahmin caste disregarded the practice of consuming alcohol, while the rest of the country had a relaxed outlook towards drinking. With improvement in trade opportunities, industrialization and influx of newer living styles heralded by the British, a drastic change of socio-economic empowerment ensued, which led to the emergence of a nouveau riche section of society termed as the "urban middle class". Individuals belonging to this section of society deemed themselves contemporary to the higher castes and started adopting their practices. Abstaining from drinking locally brewed illicit liquor became the norm. Parallel to this changing behaviour, the monopolization of liquor production and procurement by the British government was entrenched by imposing excise duty on alcohol and restricting the manufacture of alcoholic beverages only to licensed government distilleries. This again brought in a shift of drinking pattern. The lower rungs of society resorted to indulging in illicit alcohol 10 use to transcend their misery and drinking among the upper classes, in accordance to foreign customs, was a luxurious affectation. As the struggle of independence progressed, Gandhi and the nationalist movement utilized the temperament of the middle class in mobilizing mass movements against drinking to symbolize the fight against colonial oppression. They strove to make the Indian nation ritually pure and demanded for total prohibition. The Constituent Assembly of independent India included prohibition as one of the Directive Principles of state policy.

V. Statistics

Statistics of Alcoholism in Tamil Nadu

The term liquor addiction is turning into a far-reaching issue in the Indian culture and Tamil Nadu is no special case that keeps profound situated outcomes in different perspectives. The period of first enormous presentation to liquor in the state has dropped to fifteen years. An additional worry is the expanding quantities of women, exceptionally young ladies, becoming dependent on liquor. This pattern is causing financial-issues, however little is being done to capture this social pattern and social disgrace. On the contrary, the state government is firmly promising liquor abuse to pick up income as a result of the income angle. Tamil Nadu State Marketing Corporation (TASMAC) is an organization properly possessed by the Tamil Nadu government, which has an imposing business model over discount and retail distributing of mixed drinks in the state. For the state government viewpoint years have included a tremendous measure of cash to its exchequer by authorizing and offering the alcohol through its 2500 government controlled TASMAC shops. Alcohol deals in 2011-12 has contacted 18,081.16 crore rupees, enrolling a 20.82% expansion. Consistently amid the New Year and Pongal celebrations, TASMAC is making around Rs. 500 crores offering alcohol in discount and retail showcase. No legislature is sternly ready to stop it since they get income from it, however the expenses are higher managing issues caused by liquor addiction costs three times more than the measure of income the administration gets from alcohol sales. In request to 15 comprehend the greatness of the issue and to feel the beat of the general public, Nandini Voice for the Deprived, a Chennai based NGO directed a study in Tamil Nadu to find out the

perspectives of the general population about the TASMAC shops, accepted to be the main driver of this social problem. By moving with this investigation of TASMAC, there have been various unsettling gatherings of individuals in a few places in Tamil Nadu, requesting the TASMAC shops to be expelled from the neighbourhoods that have long standing issues. There were likewise challenges that the TASMAC shops ought to be banned close to the spots of love and instructive establishments. The judiciary has likewise given directions that the expressways ought to be free from the TASMAC shops. Be that as it may, this is having little effect in checking the offer of alcohol in the state. The business turnover of TASMAC shops is consistently expanding and proportionate to it the quantity of alcohol addicts is developing among different age groups.

Statistics of Alcoholism in India

Alcohol harming kills at least six individuals consistently. Around 76 percent are grown-ups between the ages 35-64 and three of each four individuals are executed by liquor harming. The strong increment of gathering with the most liquor harming passing per million individuals is American Indians/Alaska Natives (49.1 for each 1 million). In India, 15% of the individual attempting liquor gets dependence to it. Today, India is having right around 63 million liquor dependent individuals and the rate of alcoholism in India has ascended by 175% over the most recent three years. Around 35-40% of the Indian populace had expended liquor in the year 2015. Among them, 11% of the Indian populace enjoys overwhelming drinking. The per capita utilization of liquor in the year 2015-16 is around 2.5 litres which is a big figure. This demonstrates that the Indian populace is very dependent towards liquor addiction. Indians favour hard mixers and refined spirits over lagers – 80% of utilization includes these more grounded refreshments that prompt powerlessness in a more extensive point of view. It is recommended that 20% of the populace had in any event attempted liquor. In the previous two decades, the quantity of individuals who have devoured liquor has moved from 1 of every 300 to 1 of every 20. The Lancet detailed that the greater part of the individuals who expend liquor in India would fall into the classification of dangerous drinking. It has been proposed that there are a worryingly 14 million individuals in India who might be portrayed as reliant on liquor and needing assistance. Another worry is the expanding inclination to take part in hard-core boozing where individuals intentionally end up inebriated. The youthful ones are getting dependent towards liquor considerably prior and ladies are additionally enjoying overwhelming and hard-core boozing, accordingly contributing for the expanding alcoholism in India. It was seen that liquor utilization has quickly expanded, all things considered, in the province of Kerala taken after by Andhra Pradesh, Mizoram, Bihar et cetera. Regarding the sum spent per head on intoxicants every month, Mizoram positions first, trailed by Meghalaya, Manipur, and Tripura, Assam. Such figures demonstrate the expanding alcoholism in India.

Stages of Alcoholism

According to **(Center, 2021)**, the four stages of alcoholism are:

1. The Pre-Alcoholic Stage
2. Early-Stage Alcoholism
3. The Middle Alcoholic Stage
4. End-Stage Alcoholism

While further research has disproved some of the conclusions Jellinek reached in his research, he still helped lay the foundation for the ways in which we understand the progression of alcohol use disorder to this day. Each of these stages is marked by certain patterns and behavioural milestones, starting with:

The Pre-Alcoholic Stage

The first stage of the Jellinek Curve may be the hardest to identify in loved ones and yourself. Everyone is affected differently by alcohol, and the ways in which alcohol interacts with the body and mind can vary from person to person. The effects of alcohol are a result of its interaction with parts of the brain that release “neurotransmitters” or chemicals that can give you energy and tell you to feel happy or content. As drinking progresses, the brain and body adjust to the presence of alcohol. The brain gets used to having alcohol tell it to release these happy chemicals and stops releasing them on its own. This is the basis for physical dependence. In this first stage, a person may drink as an activity that helps them relax, sleep, or feel more comfortable in social situations. Because drinking is a very common part of American adult activities, the pre-alcoholic stage can be very difficult to spot. People in the pre-alcoholic stage may drink more or more often than others, but it’s not always obvious. You may notice they always have a drink in their hand at events and social functions. You may also begin to notice drinking has become their preferred way to unwind after a long day of work or a difficult week. If the person starts to habitually drink alcohol as a way to cope with the difficulties of everyday life, this is a good sign they may be in the pre-alcoholic stage.

Early-Stage Alcoholism

When a person starts to regularly binge drink and have blackouts, this is a sign they've progressed to the second stage of alcohol use disorder. Many times, especially with young adults and teens, these patterns are simply a sign of alcohol experimentation. Other times, it can be a serious sign that a person's alcohol consumption is progressing in a negative way. They may not drink every day, but they drink frequently, and most social activities and nights out involve drinking. When a person regularly drinks alcohol to excess, their body and mind start to physically and psychologically adjust, leaving them open to the progression of AUD. It is considered binge drinking when a woman consumes about four standard alcoholic drinks within a two-hour period, or a man drinks five drinks in the same amount of time. Blackouts from drinking occur when alcohol shuts down the area of the brain responsible for making memories, leading to periods of time the person doesn't remember. If a person enjoys the feeling of rapidly getting drunk, or seeks intoxication as quickly as possible, this may indicate the beginnings of a deeper issue. The signs of this stage on the Jellinek Curve are much easier to spot than those of the pre-alcoholic stage. The person will regularly binge drink and black out. Often they'll even joke about their drinking habits and swear to never drink again. This is the stage in which drinking starts to become very unhealthy and is a cause for concern.

The Middle Alcoholic Stage

When a person has progressed to this stage, their drinking habits start to become noticeable to friends and loved ones. Some people are good at hiding their drinking or lying about the extent of their drinking. At this stage, a person starts to see the negative consequences of drinking as it begins to affect their performance at school or work, and their relationships. Some major signs that a person may have progressed into the middle alcoholic phase are when they start drinking at work, are drunk while driving, or while looking after their children or other loved ones. Because the body and brain have started to adjust to the frequent presence of alcohol in their system, they need to drink more frequently and in higher amounts to reach the desired level of intoxication. Physical signs like weight gain or bloating, facial redness, shaking, sweating, and memory loss are good ways to identify a person in this stage of alcohol use disorder. Middle-stage alcoholism occurs when a person starts to prioritize drinking above their relationships, their career, and/or their education. This is also the stage where treatment for drinking can be the most beneficial. This is because the impact of drinking on their health has typically not progressed to a level that can't be reversed with healthy lifestyle changes.

End-Stage Alcoholism

When a person enters this phase, the long-term effects of heavy drinking become impossible to hide. The person may have already tried to stop drinking multiple times with little to no success. Drinking is no longer just for social occasions; it becomes an all-day activity. Priorities shift to make drinking alcohol the No. 1 priority in the person's life. This may cause a person to lose their job and even their family. It can quickly become a cycle of negative alcohol consumption that may be impossible for them to overcome on their own. A person in end-stage alcoholism can expect to have some very major health problems that include liver damage, heart disease, and other alcohol-related illnesses.

Smart Recovery

(Jeffrey D. Roth, 2016), SMART Recovery was founded by Joe Gerstein in 1994 by basing REBT as a foundation. It gives importance to the human agency in overcoming addiction and focuses on self-empowerment and self-reliance. It does not subscribe to disease theory and powerlessness. The group meetings involve open discussions, questioning decisions and forming corrective measures through assertive exercises. It does not involve a lifetime membership concept, but people can opt to attend meetings, and choose not to after gaining recovery. Objectives of the SMART Recovery programs are:

- Building and Maintaining Motivation,
- Coping with Urges,
- Managing Thoughts, Feelings, and Behaviours,
- Living a Balanced Life.

This is considered to be similar to other self-help groups who work within mutual aid concepts.

Alcohol Content

Mature beverages like brew and wine contain from 2% to 20% of liquor. Distilled beverages or alcohol contain from 40% to half or more liquor. The typical real liquor content is approximately as follows:

- Beer : 2– 6% liquor
- Cider : 4– 8% liquor
- Wine : 8– 20% liquor
- Tequila : 40% liquor

- Rum : at least 40% liquor
- Brandy : at least 40% liquor
- Gin : 40– 47% liquor
- Whiskey : 40–50% liquor
- Vodka : 40–50%liquor
- Liqueurs : 15–60% liquor

Liquor is profoundly consumed into the vital circulation system through the little veins in the dividers of the stomach and small digestive tract. After alcohol consumption the liquor contents are transferred to the mind abating the activity of nerve cells that are eminent. More or less 20% of liquor is completely absorbed by the stomach. The majority of the remaining 80% is entirely absorbed by the small digestive tract. The circulatory system sends it to the liver which disposes the liquor from the blood through a procedure called processing, where it is changed to a nontoxic substance. The liver can change the amount utilized by the body at any specific moment as it courses all through the body. When the measure of liquor in the blood surpasses a specific level, the respiratory system is affected resulting in a trance like state or demise, since oxygen does not venture into the mind, for example, right cerebrum and left mind.

Short-term effects of alcohol

Relying on the amount of intake, the physical condition and the individual's mental condition, liquor can cause:

- Slurred discourse
- Sleepiness
- Vomiting
- Diarrhoea
- Upset stomach
- Headaches
- Breathing troubles
- Distorted vision and hearing
- Impaired judgment
- Decreased discernment and coordination
- Unconsciousness
- Anaemia (loss of red platelets)
- Unconsciousness
- Blackouts (as far as memory slips, where the consumer cannot recollect occasions and occurrences that happened while impaired)

Long-term effects of alcohol

The sense and sensibility after a drinking spree followed by liquor use in expansive sums are connected with numerous medical issues including auto accident, falls, consumes, suffocating, gun wounds, rape and aggressive behaviour at home.

- Increased work wounds and loss of efficiency
- Steadily expanding family issues, broken connections
- Liquor poisoning
- Hypertension, stroke, and other heart-related ailments
- Liver sickness
- Nerve problems
- Sexual issues
- Permanent harm to the mind
- Vitamin B1 inadequacy, which can prompt a chaos described by amnesia, aloofness and confusion
- Ulcer
- Gastritis (aggravation of stomach dividers)
- Undernourishment
- Mouth cancer and throat cancer

VI. Related Studies

Family burden with substance dependence: a study from India (Surendra Kumar Mattoo, Naresh Nebhinani, 2013)

Background & objectives

A substance dependent person in the family affects almost all aspects of family life. This leads to problems, difficulties or adverse events which impact the lives of family members and causes enormous burden on family caregivers. The present study aimed to assess the pattern of burden borne by the family caregivers of men with alcohol and opioid dependence.

Methods

A cross-sectional study was conducted with ICD-10 diagnosed substance dependence subjects and their family caregivers attending a de-addiction centre at a multispecialty teaching hospital in north India. Family Burden Interview Schedule was used to assess the pattern of burden borne by the family caregivers of 120 men with alcohol and/or opioid dependence.

Results

Compared to opioid and alcohol + opioid dependence groups, more often the alcohol dependence group was older, married, currently working, having a higher income and with the wife as a caregiver. Family burden was moderate or severe in 95-100 per cent cases in all three groups and more for 'disruption of family routine', 'financial burden', 'disruption of family interactions' and 'disruption of family leisure'. Family burden was associated with low income and rural location. It was associated neither with age, education or duration of dependence of the patients, nor with family size, type of caregiver or caregiver's education and occupation.

Interpretation & conclusions

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.

Keywords: Family burden, subjective and objective burden, substance dependence

Caregiver Burden in Alcohol Dependence Syndrome (Ramanujam Vaishnavi, 2017)

Aims and objectives are as follows

(1) Assess the pattern of burden on the caregivers of patients with alcohol dependence syndrome.
(2) Assess the relationship between the severity of dependence and the burden on caregivers.

VII. Materials and Methods

Design

This cross-sectional descriptive study was conducted at the Department of Psychiatry, Sri Ramachandra Medical College and Research Institute, Porur, Chennai. Before the commencement of the study, the Institutional Ethical Committee (IEC) approval was obtained. Our IEC adheres to Indian Council of Medical Research (ICMR) guidelines for biomedical research in human beings.

Participants

The sample was comprised of 200 patients diagnosed with alcohol dependence syndrome and their 200 caregivers. The samples were inducted through consecutive sampling method.

Inclusion Criteria

The inclusion criteria were as follows: patients more than 18 years of age who were diagnosed to have alcohol dependence syndrome as per ICD-10 criteria and their caregivers who were more than 18 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. Caregivers with alcohol dependence and patients with any other dependence other than alcohol and nicotine were also excluded.

Chapterization

The research study is presented in five different chapters. Brief outline of the
chapterization is given below.

1. **Chapter 1** - Introduction and Review of Literature: This chapter comprises reviews collected, which is the secondary data required for the study, from articles, journals and research studies.

2. **Chapter 2** - Research Methodology: This chapter gives the outline about the type of methodology, design, sampling technique used for the study. The universe, sample size, criteria for sample selection and tools of data collection are also explained in this chapter.
3. **Chapter 3** - Analysis and Interpretation: This chapter consists of the data collected from the respondents which is analyzed and interpreted. The data is represented in the form of tables and figures.
4. **Chapter 4** - Discussion on the Main findings: This chapter deals with discussions about the main findings based on the analysis and interpretation of the data given in chapter 3.
5. **Chapter 5** - Suggestions and Conclusion: Recommendation and suggestions based on the findings and social work implications for this study is listed out in this chapter.

Conclusion

The present study found that there is significant burden for caregivers. In addition, the caregiver 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 caregivers which in turn will lead to better treatment effectiveness.

VIII. RESEARCH METHODOLOGY

Introduction

Research methodology is a systematic plan for conducting research. This chapter deals with the research design, sampling methods, and statement of the problem in order to achieve the objectives of the study.

Statement of the Problem

Nowadays, the consumption of alcohol among urban and rural people is increasing at a rapid rate, irrespective of their social and economic status. Alcohol consumption entails a number of health hazards, which eventually affect the valuable life of the person who is consuming it and also their family members. This problem is chronic and is becoming one of the major health problems in many countries. Particularly in India, alcohol dependence affects both the poor and the rich. Alcohol dependence has been identified as one of the most disabling social and mental health problems where the individuals are affected by serious family issues. Continued excessive alcohol consumption can lead to the development of dependence that is associated with a withdrawal syndrome when alcohol consumption is ceased or substantially reduced.

Alcoholism is a major threat to the individual as well as the society and the maximum burden of the illness is borne by the family. The study is aimed at assessing the family caregivers of alcohol dependent patients. Alcohol dependence is considered 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.

Alcohol use disorder (AUD), commonly called alcoholism, is often called a “family disease” because it impacts more people than just the individual with alcohol addiction. Addiction happens in all types of families, and its emotional side effects are felt by spouses, children, and other loved ones. Their lives, behaviours, and attitudes can change forever as a result of the disease. They can even experience anxiety, depression, and shame as a result of alcohol addiction. Living in a home with AUD can lead to disruptive behaviour, tension, and strained relationships—all of which can cause significant stress on the family unit.

Importance of the study

An alcohol dependent person in the family affects almost all aspects of family life, e.g., interpersonal and social relationships, leisure time activities, and finances. Alcohol dependence invariably increases conflicts, negatively affects family members, and burdens the families. The psychological and behavioural impact on others is often far greater than on the substance dependent family member. Yet, because of the historical emphasis on substance dependence as an individual's problem, the study of family's problems has been relatively neglected. Consequently, systematic research on substance dependence related burden among the family members is very limited.

Alcohol use, particularly alcohol use that meets criteria for abuse or dependency, is a cause for concern among caregivers, as both their life and the life of their care recipient is at risk, particularly if they are responsible for assisting their care recipient with activities of daily living. While the relationship between caregiver burden and mental and physical health will be studied in great detail, the relationship between caregiver burden and alcohol use has largely been ignored.

General objective

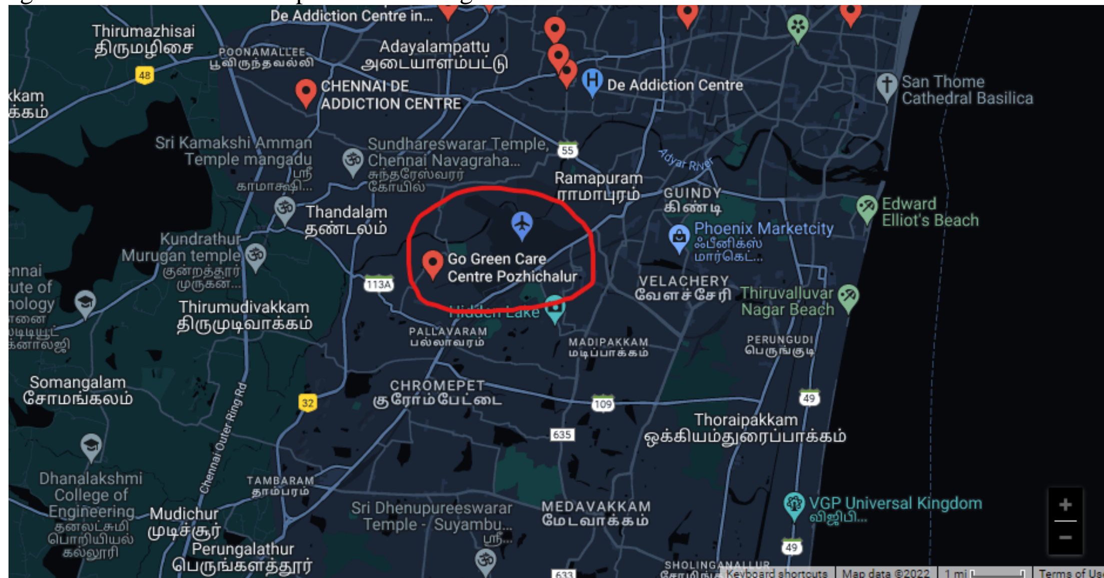
To study about the family caregivers of alcoholic patients residing in de-addiction centres

Specific objective

- To study the level of burden faced by the caregivers of alcoholic patients getting treatment in de-addiction centres
- To understand the coping used by the caregivers of alcoholic patients getting treatment in de-addiction centre
- To study the challenges faced by the caregivers of alcoholic patients getting treatment in de-addiction centres
- To study the services provided by the de-addiction centre to the caregivers of alcoholic patient

Field of study

The researcher opted Go green care de-addiction centre in Chennai, where alcoholic patients are admitted and getting treatment for alcohol dependence during the time of data collection.



Research method

The researcher adopted mixed methodology. The quantitative method was used to study the burden level faced by the caregivers of alcoholic patients getting treatment in de-addiction centre and to understand the coping used by the caregivers of alcoholic patients getting treatment in de-addiction centre. Qualitative method was used to study the challenges faced by the caregivers of alcoholic patients getting treatment in de-addiction centres and to study the services provided by the de-addiction centre to the caregivers of alcoholic patients.

Research Design

The researched used sequential explanatory design. In this model the researcher first collected and analysed the quantitative data in the first phase followed by qualitative data which was collected in the second phase of the study.

Universe

The universe includes family caregivers of the alcoholic patients who are getting treatment in the go green care de-addiction centre, Chennai.

Sample size

Quantitative: The sample size for quantitative was 44 respondents.

Qualitative: The qualitative sample size was 6 respondents.

Sampling technique

Quantitative

The researcher used purposive sampling technique to collect data form the respondents, who are primary family caregivers of the alcoholic patients getting treatment in the de-addiction centre.

Qualitative

The researcher used purposive sampling technique to collect data form the respondents, who are primary family caregivers of the alcoholic patients getting treatment in the de-addiction centre.

Criteria of the sample size

Respondents should be the primary family caregivers of the alcoholic patients getting treatment in the de-addiction centres.

Source of data collection

Primary data:

The researcher collected the required information through a primary source which is from the respondent directly by Questionnaire for quantitative method and In-Depth interview for qualitative method.

Secondary data

The researcher collected Secondary data from books, journals, research papers, other published articles and websites relevant to the research topic.

Tools for data collection

Questionnaire was used for collecting the data in a quantitative method framed on the above mentioned objectives of the study, and an in-depth Interview guide was used for the qualitative method. The English tool was translated into Tamil and was verified and attested by a Tamil Professor.

Scales used in the research questionnaire

Zarit Caregiver Burden Assessment Scale (1980)

Pre-test

The pre-test data for quantitative method was collected on 23rd January 2022
The pre-test data for qualitative method was collected on 2nd April 2022

Data collection date

Quantitative

The researcher used an informed consent form to get consent from the participants which was attached along with the starting of the questionnaire. The quantitative data was collected between February 4th and 27th March 2022.

Qualitative

The qualitative data was collected on April 3rd and April 4th, 2022.
Total timings for qualitative - (166 mins)
Average timing for each interview - (28 mins)

Limitations of the study

- Some of the caregivers who come to the de-addiction centre for visit have been already exhausted, depressed, or physically ill because of the patient. Many of them didn't want to dwell on those things again by participating in the research.
- Participants were very scared to participate as they think that the patient will be troubled in the centre with the data they share.
- Insincerity in some participants.

Research ethics

A written consent form was obtained for both qualitative and quantitative data. The respondents who participated in the research were on a voluntary basis. The participants of the research have been given an overview of the purpose of the study and assured that the information gathered through them will be of confidential nature and will be used only for research purposes.

Analysis

The quantitative data was analysed using SPSS (Statistical package for social sciences) and MS Excel. Qualitative data has been analysed by open coding and axial coding.

Definition of terms

Caregivers

Conceptual definition:

A person who gives care to people who need help taking care of themselves. Examples include children, the elderly, or patients who have chronic illnesses or are disabled. Caregivers may be health professionals, family members, friends, social workers, or members of the clergy. They may give care at home or in a hospital or other health care setting (NCI DICTIONARY).

Operational definition:

In this study, caregivers refer to **primary family caregivers** who stay along with the patient in a house and take cares of the alcoholic patient.

Alcohol dependent

Conceptual definition:

- A chronic disease in which a person craves drinks that contain alcohol and is unable to control his or her drinking. A person with this disease also needs to drink greater amounts to get the same effect and has withdrawal symptoms after stopping alcohol use. Alcoholism affects physical and mental health, and can cause problems with family, friends, and work.
- A disorder characterized by a pathological pattern of alcohol use that causes a serious impairment in social or occupational functioning (ICD-10).

Operational definition:

According to this study alcohol dependence refers to Alcohol use disorder or alcohol addiction by the patients which affects the family caregivers of the addicted patient.

Conclusion

The above are the details of the Research Methodology which included the nook and corner of the techniques and tools the researcher utilised for the research.

IX. ANALYSIS AND INTERPRETATION

Introduction

In this chapter the analysis and interpretation are done using SPSS and the data is represented in form of tables and figures

Section – 1: Quantitative data

Personal details of the respondents

Table 3.1 Age of the respondents

Age	No of respondents	Percentage
Didn't mentioned	16	36.4
20	2	4.5
23	2	4.5
24	1	2.3
25	2	4.5
26	5	11.4
27	2	4.5
28	4	9.1
30	1	2.3
31	1	2.3
32	1	2.3
33	1	2.3
36	2	4.5
37	1	2.3
39	1	2.3
46	1	2.3
48	1	2.3
Total	44	100.0

Table 3.1 represents the age of the respondents, more than one third of the respondents haven't mentioned their age, less than half of the respondents were between the ages 20-30 years, while, a considerable proportion of the respondents were between 31-50 years of age.

Table 3.2 Biological sex of the respondents

Sex	No of respondents	Percentage
Male	16	36.4
Female	28	63.6
Total	44	100.0

Table 3.2 represents the biological sex of the respondents where more than two third (63.6%) of respondents were female and more than one third (36.4%) of the respondents were female.

Table 3.3 Domicile type of the respondent

Domicile	No of respondents	Percentage
Rural	7	15.9
Urban	37	84.1
Total	44	100.0

Table 3.3 represents the domicile type of the respondents, A vast majority of the respondents (84 %) belongs to urban and a considerable proportion (15%) of the respondents are form rural domicile.

Table 3.4 Educational status of the respondent

Educational status	No of respondents	Percentage
Illiterate	7	15.9
Primary	3	6.8
Secondary	8	18.2
Higher Secondary	6	13.6
Graduate	13	29.5
Post Graduate	7	15.9
Total	44	100.0

Table 3.4 reveals the educational status of the respondents. More than one third (37 %) of the respondents have done schooling, One fourth of the respondents (29.5 %) were graduate, a considerable proportion of the respondents were post graduate (15.9 %) and illiterate (15.9 %).

Table 3.5 Marital status of the respondent

Marital status	No of respondents	Percentage
Married	29	65.9
Unmarried	10	22.7
Divorced	2	4.5
Separated	1	2.3
Widowed	1	2.3
Others	1	2.3
Total	44	100.0

Table 3.5 represents the marital status of the respondent. More than two third (65.9 %) of the respondents were married, less than one fourth (22.7 %) of the respondents were unmarried, and a considerable proportion of respondents were divorced (4.5 %), separated (2.3 %), widowed (2.3 %), others (2.3 %).

Table 3.6 Type of family

Type of family	No of respondents	Percentage
Nuclear	32	72.7
Joint	12	27.3
Total	44	100.0

Table 3.6 represents the type of family of the respondents. Three fourth (72.7 %) of the respondents were of nuclear family and one fourth (27.3 %) of the respondent were of joint family.

Table 3.7 Family size

Family size	No of respondents	Percentage
Not mentioned	12	27.3
2	5	11.4
3	5	11.4
4	10	22.7
5	7	15.9
6	1	2.3
7	2	4.5
8	2	4.5
Total	44	100.0

Table 3.7 represents the family size of the respondents. One fourth of the respondents (27 %) didn't mentioned their family size, less than fourth (22 %) of the respondents family size were 4 members, a considerable proportion of the respondents family members size were 2 members (11 %), 3 members (11 %), 5 members (15 %), 6 members (2 %), 7 members (4 %), 8 (4 %).

Table 3.8 Occupation of respondents

Occupation	No of respondents	Percentage
Unemployed	7	15.9
Professional	5	11.4
Retired	1	2.3
Housewife	6	13.6
Unskilled worker	13	29.5
Business	6	13.6
Daily wages	6	13.6
Total	44	100.0

Table 3.8 represents the occupation of the respondents. One fourth of the respondents (29 %) were unskilled workers, a considerable proportion of the respondents were unemployed (15 %), professional (11 %), retired (2 %), house wife (13 %), business (13 %), daily wages (13 %).

Table 3.9 Monthly income of the respondents

Monthly income	No of respondents	Percentage
Not earning or working	20	45.5
9000	1	2.3
10000	2	4.5
12000	2	4.5
15000	3	6.8
16000	1	2.3
18000	1	2.3
20000	3	6.8
24000	1	2.3
25000	1	2.3
30000	1	2.3
35000	3	6.8
40000	1	2.3
42000	1	2.3
45000	1	2.3
52000	1	2.3
55000	1	2.3
Total	44	100.0

Table 3.9 represents the monthly income of the respondents, less than half of the respondents (45 %) were not working or earning, one fourth (26 %) of the respondents were earning between 9000 – 20000 rupees, a considerable proportion of the respondents were earning between 21000 – 40000 (14 %), between 41000 – 55000 (8 %).

Table 3.10 Religion

Religion	No of respondents	Percentage
Hindu	22	50.0
Muslim	9	20.5
Christian	13	29.5
Total	44	100.0

Table 3.10 reveals the religion of the respondents, half of the respondents (50 %) were Hindu, less than one fourth (20.5 %) of the respondents were Muslim and one fourth (29.5 %) of the respondent were Christians.

Table 3.11 Mother tongue

Mother tongue	No of respondents	Percentage
Tamil	40	90.9
Telugu	3	6.8
Hindi	1	2.3
Total	44	100.0

Table 3.11 reveals the mother tongue of the respondents, absolute majority of the respondents (90.9 %) were Tamil, a considerable proportion of respondents were Telugu (6.8 %), Hindi (2.3 %).

Table 3.12 Relationship with the patient

Relationship with patient	No of respondents	Percentage
Mother	6	13.6
Father	6	13.6
Brother	7	15.9
Sister	4	9.1
Wife	14	31.8
Daughter	1	2.3
Son	1	2.3
Friend	5	11.4
Total	44	100.0

Table 3.12 represents the relationship of the respondents with the patient, more than one fourth (31 %) of the respondents were wives of the patients, a considerable proportion of the respondents were mother (13 %), father (13 %), brother (15 %), sister (9 %), daughter (2 %), son (2 %) and friend (11 %).

Table 3.13 Respondent duration of stay with the patient

Duration of stay with patient	No of respondents	Percentage
Less than one year	8	18.2
1-3 Years	6	13.6
4-6 Years	7	15.9
7-9 Years	4	9.1
More than 10 Years	19	43.2
Total	44	100.0

Table 3.13 reveals the respondents duration of stay with the patients, less than half (43.2 %) of the patient were staying more than 10 years with the patient, a considerable proportion of the respondents were staying less than one year (18.2 %), 1 – 3 years (13.6 %), 4 – 6 years (15.9 %), 7 – 9 years (9.1 %).

To study the level of burden faced by the caregivers of alcoholic patients getting treatment in de-addiction centres

Table 3.14
Do you feel that the patient asks for more help than they need?

Patient asks for more help	No of respondents	Percentage
Never	2	4.5
Rarely	3	6.8
Sometimes	3	6.8
Frequently	20	45.5
Nearly always	16	36.4
Total	44	100.0

Table 3.14 represents the respondents feeling on the patient asking more help than they need, less than half of the respondents (45.5 %) feels Frequently, more than one third (36.4 %) of the respondents feels Nearly always, a considerable proportion of the respondents feels never (4.5 %), rarely (6.8 %) and sometimes (6.8 %).

Table 3.15
Do you feel that, because of the time you spend with the patient, you don’t have enough time for yourself?

Don’t have enough time for yourself	No of respondents	Percentage
Never	7	15.9
Rarely	4	9.1
Sometimes	10	22.7
Frequently	11	25.0
Nearly always	12	27.3
Total	44	100.0

Table 3.15 represents the respondents feeling on not having enough time for themselves because of the patient, one fourth of the respondents feel nearly always (27.3 %) , frequently (25 %), less than one fourth of the respondents feel sometimes (22.7 %), a considerable proportion of the respondents feel never (15.9 %)and rarely (9.1 %).

Table 3.16
Do you feel stressed between caring for the patient and trying to meet other responsibilities for your family or work?

Feel stressed	No of respondents	Percentage
Never	3	6.8
Rarely	7	15.9
Sometimes	5	11.4
Frequently	20	45.5
Nearly always	9	20.5
Total	44	100.0

Table 3.16 represents the respondents feeling of stressed on caring for the patient less than half of the respondents feel frequently (45 %), less than one fourth of the respondents feel nearly always (20.5 %), a considerable proportion of the respondents feel rarely (15%), sometimes (11.4 %) and never (6.8 %).

Table 3.17
Do you feel embarrassed about the patient behaviour?

Feel embarrassed	No of respondents	Percent
Never	2	4.5
Rarely	2	4.5
Sometimes	12	27.3
Frequently	9	20.5
Nearly always	19	43.2
Total	44	100.0

Table 3.17 reveals the respondents feeling of embarrassment about the patient behavior, less than half of the respondents feel nearly always (43 %), one fourth of the respondents feels sometimes (27.3 %), a considerable proportion of the respondents feels frequently (20.5 %), never (4.5 %), rarely (4.5 %).

Table 3.18
Do you feel angry when you are around the patient?

Feel angry	No of respondents	Percentage
Never	3	6.8
Rarely	7	15.9
Sometimes	11	25.0
Frequently	7	15.9
Nearly always	16	36.4
Total	44	100.0

Table 3.18 represents the respondents feeling of angry when they are around the patient, more than one third of the respondents feel nearly always (36.7 %), one fourth of the respondents feels sometimes (25 %), a considerable proportion of the respondents feels frequently (15.9 %), rarely (15.9 %), never (6.8 %).

Table 3.19
Do you feel that the patient affects your relationships with other family members or friends in a negative way?

Affects your relationships	No of respondents	Percentage
Never	6	13.6
Rarely	1	2.3
Sometimes	8	18.2
Frequently	13	29.5
Nearly always	16	36.4
Total	44	100.0

Table 3.19 represents the respondents feeling of the patient affecting the respondents relationship with others in a negative way, more than one third of the respondents feels nearly always (36.4 %), less than one third of the respondents feels frequently (29.5 %), a considerable proportion of the respondents feels sometimes (18.2 %), rarely (2.3 %), never (13.6 %).

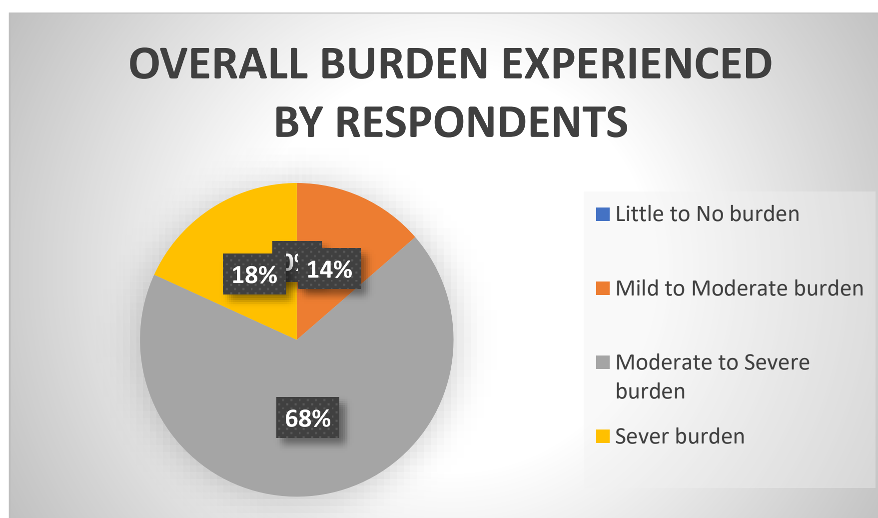


Figure 3.1

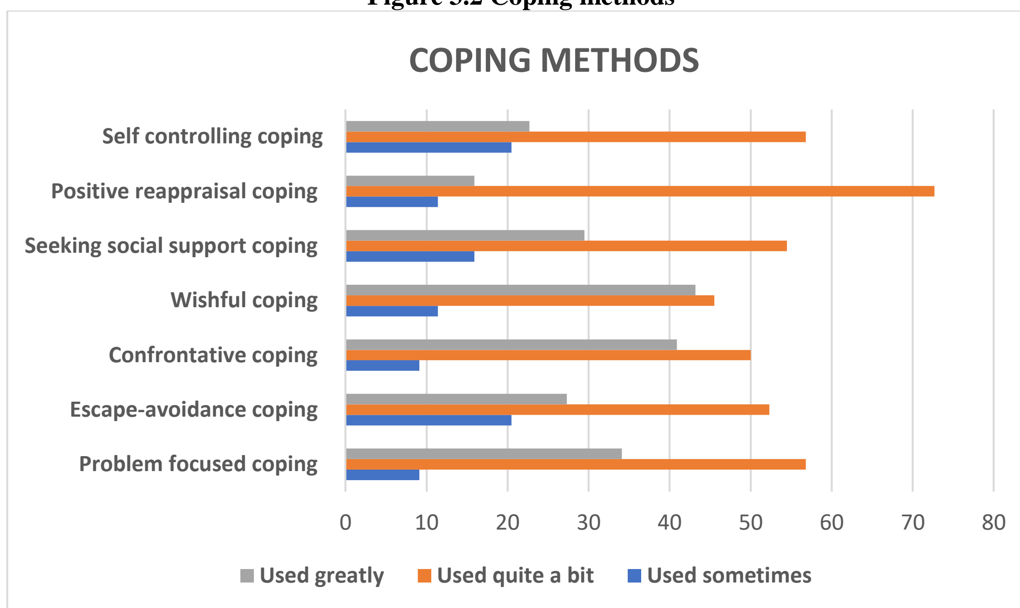
Figure 3.1 reveals the overall burden level experienced by the respondents after scoring as mentioned in the scale, (68 %) of the respondents experience (Moderate to Severe burden), (18 %) of the respondents experienced Severe burden, (14 %) of the respondents experienced (Mild to Moderate burden), Little to no burden has not experienced by any of the respondents.

Coping Analysis

The coping methods used by the respondents are categorized by the theory proposed by (Folkman and Lazarus 1988, Lazarus 1991), Lazarus and co-workers distinguish eight groups of coping strategies: confrontative coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem- solving, and positive reappraisal.

The questions as been categorized according to the factors of coping proposed by Folkman and Lazarus, The coping method sets in total has 37 items, problem focused coping has 4 items, escape-avoidance coping has 7 items, confrontative coping has 3 items, wishful coping has 3 items, seeking social support coping has 4 items, self-controlling coping has 4 items, positive reappraisal coping has 10 items, for all the different sets of coping the scoring has been done individually by taking the least and highest possible scoring in the set and the range has been calculated and soring has been done by categorizing into Used never, Used sometimes, Used quite a bit, Used greatly.

Figure 3.2 Coping methods



The above mentioned chart reveals the respondents' level of use of the different coping methods, Problem focused coping has been Used sometimes by a considerable proportion of respondents (9.1 %), half of the respondents used quite a bit (56.8 %), one third of the respondents used greatly (34.1 %).

Escape avoidance coping has been used sometimes by less than one fourth of the respondents (20.5 %), used quite a bit by half of the respondents (52.3 %), used greatly by one fourth of the respondents (27.3 %).

Confrontative coping has been used sometimes by a considerable proportion of the respondents (9.1 %), used quite a bit by half of the respondents (50 %), used less than half of the respondents (40.9 %).

Wishful coping has been used sometimes by a considerable proportion of the respondents (11.4 %), less than half of the respondents used quite a bit (45.5 %), used greatly (43.2 %).

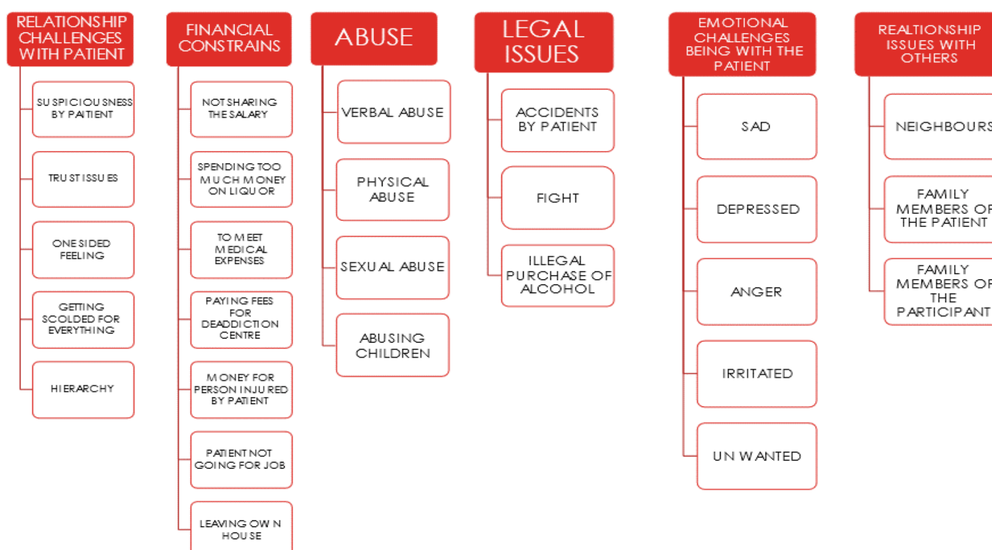
Seeking social support coping has been used sometimes by a considerable proportion of the respondents (15.9 %), used quite a bit by half of the respondents (54.5 %), less than one third of the respondents used greatly (29.5 %)

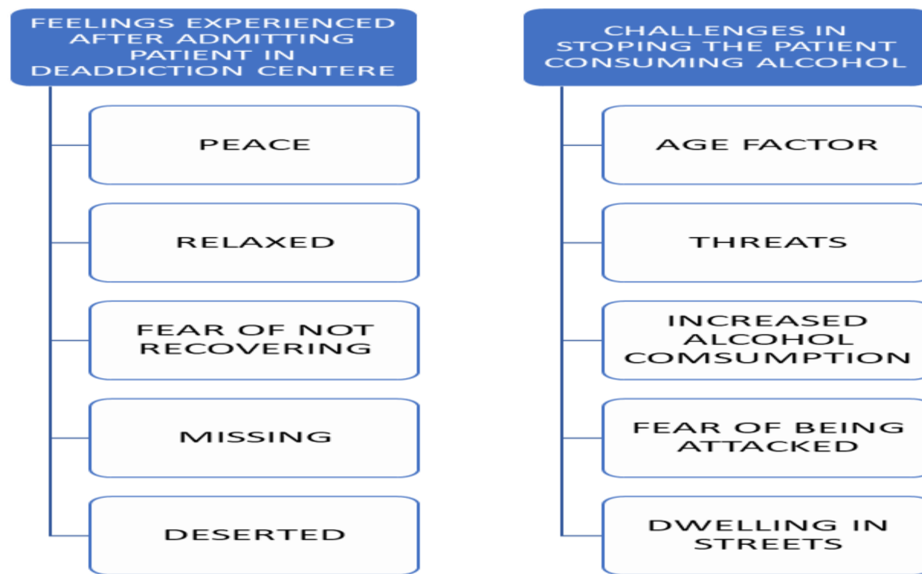
Positive reappraisal coping has been used sometimes by a considerable proportion of the respondents (11.4 %), used greatly (15.9 %), vast majority of the respondents used quite a bit (72.7 %).

Self-controlling coping has been used by less than one fourth of the respondents, sometimes (20.5 %), used greatly by (22.7 %), half of the respondents used quite a bit (56.8 %).

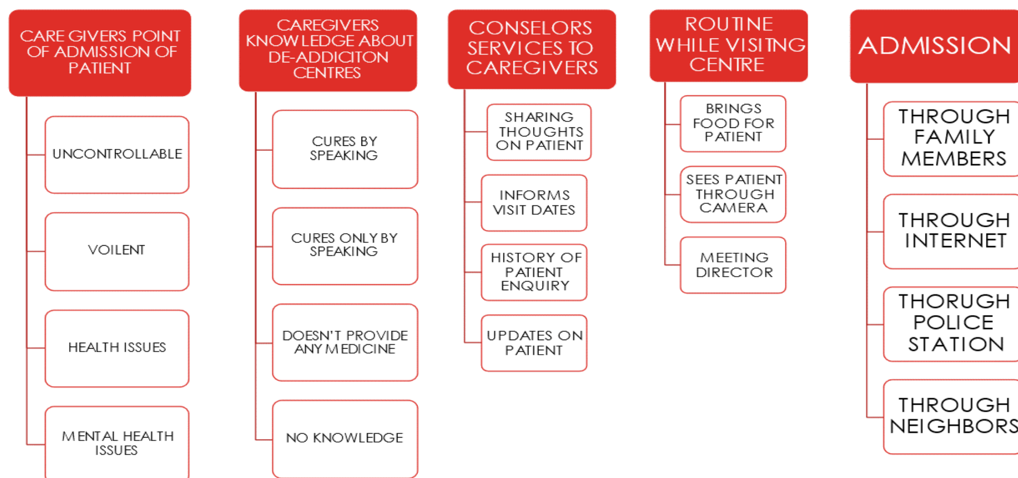
X. EMERGING THEMES

To study the challenges faced by the caregivers of alcoholic patients getting treatment in de-addiction centres





To study the services provided by the de-addiction centre to the caregivers of alcoholic patient



Theme 1: Relationship challenges with the patient

There are so many relationship problems for the participants with the alcoholic patient, as they are the one who stays with them the most of the time, even though they are the one who cares for the patient despite of all the troubles they get by the patient, they are the one who faces a lot of relationship challenges with the patient.

Suspiciousness by the patient

The patient has suspiciousness thought with the participant as a result of being a alcoholic, they think that the participant has affair with someone so that they want to put the patient in the de-addiction centre so that the patient wouldn't be a problem for them, they also think that the participant has affair in the workplace.

Trust issues

The participant feels that as a result of alcoholism, the patient started telling lies in everything to drink, especially in money matters, the patient tells lot of lies to hide money to drink, it is becoming a major problem in the relationship that the participant couldn't believe the patient in anything they claims.

One sided feeling

The participants feels that they only care for the patient, they only doing everything for the patient out of love and care, even then the patient doesn't care or think about the participant's struggle and doesn't want to realize the things the participant does for the patient, it makes the participant feels that they are the one who has love and care but not in the other end.

Getting scolded for everything

The participants claims that the patient scolds them for everything whenever they are drunk, if the participant asks anything small also, the patient will start scolding them for long time and it leads to many problems the participants claim.

Hierarchy

The patient feels that the participant must obey them in everything and shouldn't question them on anything even if the patient is doing anything, the patient wants to maintain the hierarchy all the time whenever they are drunk and in home with the participant. It leads to conversations and problems.

Sex with multiple partners

The patient has sex with many people outside, which leads to relationship problems with the participant, if the participant asks the patient attacks them or doesn't matter them as a person.

Figure 3.3

Theme 2: Relationship problems with others

As a result of being the caregiver of the alcoholic patient the participant faces lot of relationship problems with others, they have been humiliated, left alone and deserted as they are being a caregiver of a problems, it is all because of what the patient does affects the relationship between the participants and others.

Family members of the patient

The family members of the patient blames the participant for the patient being a alcoholic, they blames the participant that because of them only the patient is being an alcoholic, the patient gets into fight with everyone in the family that they show their anger and disappointment to the participant as they couldn't do it to the patient.

Family members of the participants

The family members of the participant humiliates the participant, compares them with other person in the family, as the participant has an alcoholic person in their family, the family members of the participant doesn't even want to visit the participant or their children as they have an alcoholic in their family.

Neighbors

The participants claims that the patient picks up fights with the neighbors and creates problems with them, as a result they show their anger to the participant, which makes the participant hesitate even to come out of the house, the participant feels that they are being punished for the things that they didn't do.

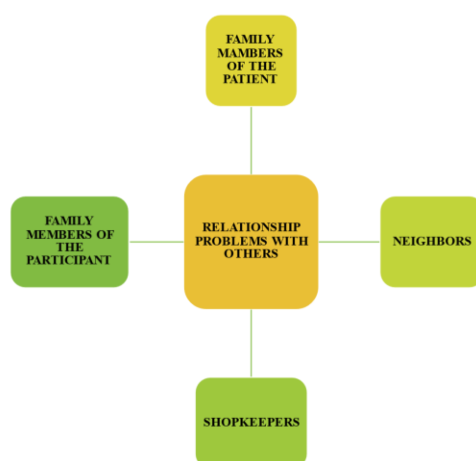


Figure 3.4

Theme 3: Financial constrains

The participants face financial constrains because of the patient being a alcoholic, they face financial crisis in many situation caused by the patient, whereas the participant has to deal all the financial constrains alone as the patient doesn't support them.

Not sharing salary

The patient doesn't share their salary if at all they are going to job, they spend all of their money earned to buy alcohol only, they doesn't support the family with whatever they earns, they keep all the money with them, which makes very difficult for the participant even if the patient is going for job the participant has to carry the burden and be the breadwinner of the family.

Spending too much on liquor

The patient spends a lot of money on liquor, troubles the participant all time to give money to drink, spends the money earned by the participant on liquor, if they refuse to give the patient picks up fight and makes issues.

Medical expenses

As a result of alcoholism the patient is been affected with lot of health issues and meet with accidents, where the participant has to spend money for the medical expenses of the patient, which makes very difficult to the participant to balance the money. The participant has to pay the fees for the treatment of the patient every month, which makes very difficult for the participant to meet their daily needs.

Money spent for damage caused to other by the patient

The participant has to spend money for the damage caused by the alcoholic patient, as they picks up fight with unknown persons and make injury to them, also the patient does accidents in vehicles, where the participant has to pay for the treatment of the injured person and for the damages caused by the patient.

Patient not going or job

As the patient is being drunk all the time, they won't go for any job and support the family along with the participant, which leads to financial problems to the participant as they has to take care of the financial sides as one person.

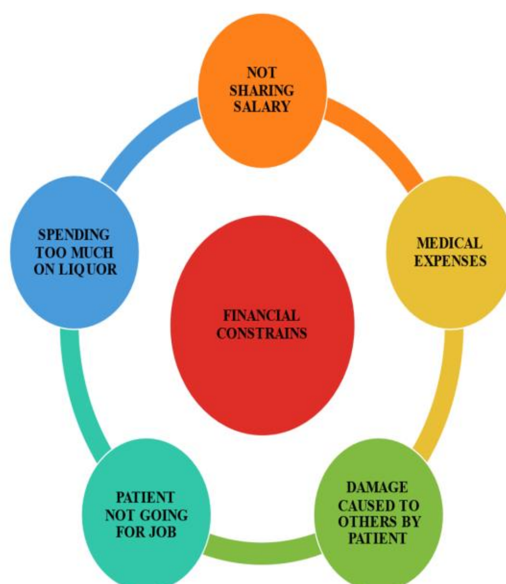


Figure 3.5

Theme 4: Abuse

The patient abuse the participant verbally, physically and sexually when they are drunk, the participant are prone to traumas because of this and it also make them suffer a lot in day to day life as it is been done every day to the participant.

Verbal abuse

The participant faces verbal abuse form the patient during any conflicts or even without any reasons the participant has been verbally abused by the patient.

Physical abuse

The participant has faced physical abuse from the patient, if the participant asks anything to the patient about their drinking habits and addiction the patient gets angry in them starts fighting with the participant and beats them up.

Sexual abuse

The patient abuses the participant in means of having sex with them for a long time, even all night as they are drunk, they wants to have sex with them every time, the participant claims that the patient uses them as a tool to have sex.

Abusing children

The participant claims that the patient abuses the children verbally and physically by beating them up when the patient is drunk.

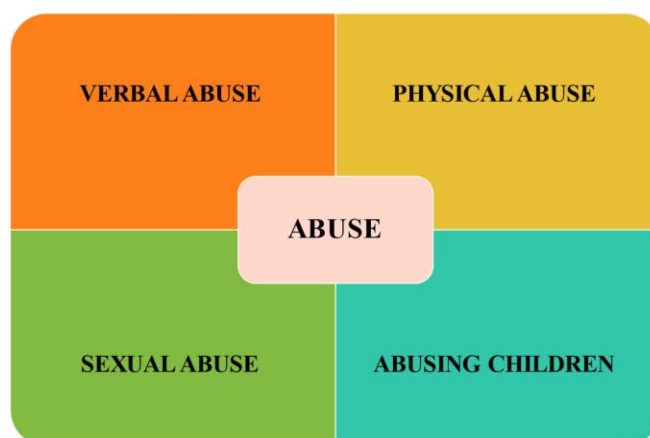


Figure 3.6

Theme 5: legal issues

There are many legal issues caused by the patient where the participants has to spend their time, money and effort to solve the problems caused by the patient and make things normal, it is been a routine in their life the participants claims.

Accidents

The patient makes a lot of accidents when they are being drunk, which leads to legal issues, where the participant must spend money and time for the damage caused by the patient when they're drunk.

Fights

The patient picks up fight in the road with unknown persons, shopkeepers and neighbors which leads to legal issues where the damaged person complaint against the patient.

Illegal purchase of alcohol

The patient has been arrested by the policemen for purchasing alcohol illegally after the closing of wine shops or purchasing during the government holidays.

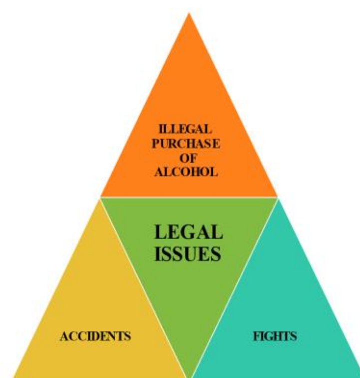


Figure 3.7

Theme 6: Emotional challenges being with the patient

The participant faces emotional challenges being with the patient, as a result of the patients behavior and activities, the participants suffers emotionally being with them.

Depressed

The participant feel depressed being with the patient as they emotionally abuse them every time when they are with the participants.

Feeling unwanted

The participant feels unwanted as the patient doesn't show any care or wanted feeling with the patient, so the participant feels they are the one who cares for the patient but the patient doesn't show any wanted feeling towards them, as they don't realize the efforts and struggles of the participants.

Irritated

The participant feels irritated by the activities and behavior of the patient after they are drunk and being with them makes the participants irritated, the participant claims that they don't even feel like seeing the patient face as they are making them irritated all the time by their activities.

Fear

The participant feels fear because of the patient as they don't know what they will do, what new problems they will bring to home every day, the participant will be in fear every time thinking all these thinks in their mind.

Figure 3.8

Theme 7: Feeling after admitting he patient in de-addiction centre

The participants feel different emotions after admitting the patient in the de-addiction centre; it also disturbs the participants' day to day life.

Missing

The participant misses the patient after admitting the patient in the de-addiction centre, it makes them suffers a lot that they feel like couldn't even live without the patient not being with them when the patient are getting treatment in the de-addiction centre.

Relaxed

Almost every patient feel relaxed after admitting eh patient in the centre, even though they feel depressed or sad being without the patient, they feel relaxed as they are free from the problems made by the patients.

Peace

The participant claims that they are at peace after admitting the patient in the de-addiction centre, without any troubles caused by the patient.

Deserted

The participants feel deserted as they are staying alone without the patient in the home, after admitting the patient in the de-addiction centre.

Fear of relapse

After admitting the patient in the de-addiction centre the participant get a fear of relapse of the patient after the treatment, when the patient is getting treatment in the centre the participants feels fear like what they will do if the participant come home and does the same thing.

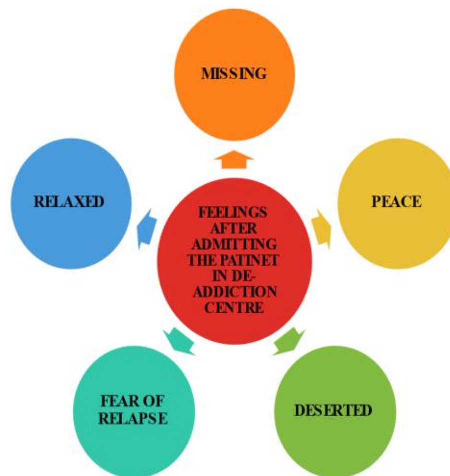


Figure 3.9

Theme 8: Challenges in stopping the patient consuming alcohol
Threatening

The patient threatens the participant if they try to make the patient stop consuming alcohol, the patient threatens that they will do any harm to themselves if the participant tries to make the patient stop taking alcohol.

Age factor

The participant claims that they couldn’t able to stop the patient taking alcohol as they are not mature enough when they get married as they are too young to identify and assess what the patient is doing and if they are addicted or what.

Dwelling in streets

If the participant tries to ask question on their behavior and drinking patterns, and tries to stop them taking alcohol the patient consumes alcohol and doesn’t turn up home, instead they will start dwelling in streets.

Fear of being attacked

If the participant tries to make the patient stop consuming alcohol by advising or speaking anything to them the patient will attack the participant they will hurt them physically claims the respondents.

Increased consumption of alcohol

The patient will consume lot of alcohol if the participant tries to stop them taking alcohol, the patient take lot of alcohol comparing to what they consume usually and makes problem after that.

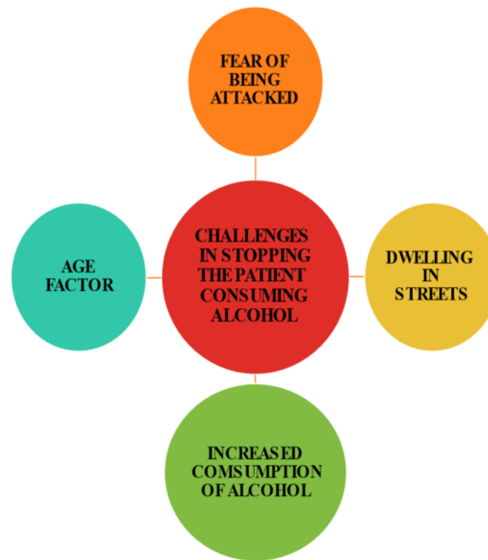


Figure 3.10

Theme 9: Admission

The mode of admission, how the patient is been admitted in the de-addiction centre by the participants, through which referral the participant get to know about the centre has been assessed here.

Through internet

The participants get to know about the de-addiction centre through internet and admitted the patient after the inquiry made through internet with the centre.

Through family members

The participant admitted the patient in the de-addiction centre after the recommendations made by the family members. The family members searched about the de-addiction centers and help the participants in admitting the patient.

Through police station

The patient has been admitted in the de-addiction centre by the participant by the referral done by the police men, the police men has introduced the centre to the participant and giving knowledge about the de-addition centre.

Through neighbors

The participants have admitted the patient through the help of the neighbors, who recommend the patient to get treatment in the de-addiction centre after witnessing the behaviors by the patient.

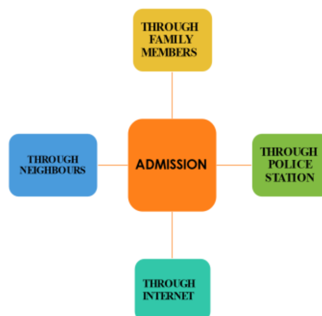


Figure 3.11

Theme 10: Caregivers knowledge about de-addiction centre

Cures by speaking

The participant before admitting the patient in the de-addiction centre the participant thinks that they cure the participant addiction only by giving counseling and speaks with the patient.

Knows nothing

The participant before admitting the patient in the de-addiction centre claims that they doesn't know anything about the de-addiction centre, they got to know about it after admitting the patient in there.

Doesn't provide medicines

The participants think that the de-addiction centre doesn't provide any medicines during the treatment of the patient in the de-addiction centre.

Figure 3.12

Theme 11:Point of admission of the patient in de-addiction centre by the caregivers

The point of time where the participant decides to admit the patient in the de-addiction centre for treatment, when the participant thought the patient needs treatment is assessed critically here, the participants decided to admit the patient during the peak times where they couldn't control the patient or the patient got serious health issues as a result of alcoholism.

Uncontrollable

The participant has decided to admit the patient when the patient has become uncontrollable in every means because of over drinking, the participants deicide to admit them to get treatment at that point of time.

Violent

The participants admit the patient to get treatment at a point where the patient become very violent and starts picking up fights with the family members for everything.

Health issues

The participant have admitted the patient when they started suffer from health issues a result of over consuming of alcohol.

Mental health issues

Patients have been admitted in de-addiction centres when the participant find the onset of mental health issues.

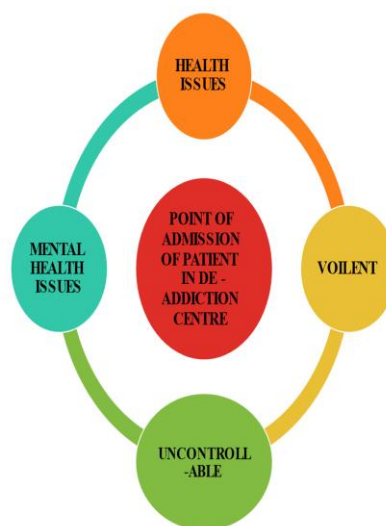


Figure 3.13

Theme 12: Counselors services for the caregivers

Sharing the thoughts on patient

The counselor in the organization shares their thoughts on the patient to the participant, they share what the patient said to the counselors to the participant.

History of the patient

The counselor asks for the family issues, history of the patient in means of consuming alcohol and he past life of the patient to the participants, when they visit the counselors during the visit to the centre.

Updates on the patient

The counselor in the centre speaks to the participant through phone calls and updates on the patient to the participant.

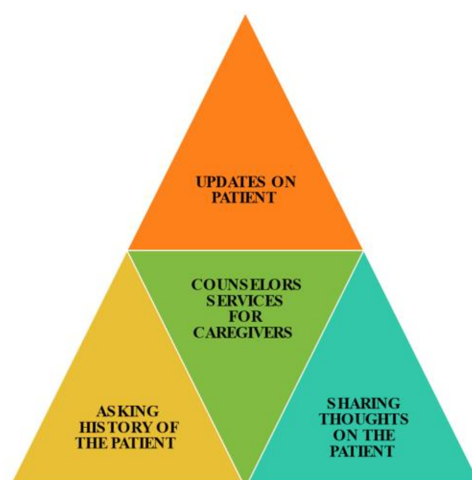


Figure 3.14

XI. DISCUSSION ON MAIN FINDINGS

Caregivers rather than the caregiving burden, faces a lot of challenges and problems in their day to day life, which is brought to them by the patients. Along with the caregiving stress they had to face many issues personally, emotionally, psychologically, socially, the caregivers doesn't get enough ventilation in their process of caregiving for an alcoholic patient, they have been left out, humiliated and hated by others as they are with the alcoholic patient.

The salient findings of the research

1) Demographic details of the respondents
2) Level of burden faced by the respondents
3) Different coping methods used by the respondents
4) Relationship challenges faced by the participants
5) Financial constraints faced due to the patient by the participants
6) Participant feeling after admitting the patient in de-addiction centre
7) Participant knowledge and awareness on de-addiction centre
8) Counseling services provided to the participants by the de-addiction centre
9) Challenges in stopping the patient consuming alcohol

Demographic details of the respondents

More than one third of the respondents haven't mentioned their age, less than half of the respondents were between the ages 20-30, while, a considerable proportion of the respondents were between 31-50 years of age. The biological sex of the respondents were more than two third (63 %) of respondents were female and more than one third (36 %) of the respondents were female. A vast majority of the respondents (84 %) belongs to urban and considerable proportions (15 %) of the respondents are form rural. More than one third (37 %) of the respondents have done schooling, One fourth of the respondents (29 %) were graduate, a considerable proportion of the respondents were post graduate (15 %) and illiterate (15 %). More than two third (65 %) of the respondents were married, less than one fourth (22 %) of the respondents were unmarried, and a considerable proportion of respondents were divorced (4%), separated (2%), widowed (2%), others (2%). Three fourth (72 %) of the respondents were of nuclear family and one fourth (27 %) of the respondent were of joint family. More than one fourth (31 %) of the respondents were wives of the patients, a considerable proportion of the respondents were mother (13 %), father (13 %), brother (15 %), sister (9 %), daughter (2 %), son (2 %) and friend (11 %). Less than half (43 %) of the patient were staying more than 10 years with the patient, a considerable proportion of the respondents were staying less than one year (18 %), 1 – 3 years (13 %), 4 – 6 years (15 %), 7 – 9 years (9 %).

Level of burden faced by the respondents

According to a study by **(Zhu Liu, 2020)** on the caregiver burden showed that the antecedents of caregiver burden are insufficient financial resources, multiple responsibility conflict and lack of social activities.

Financial and economic restraint is an important factor associated with caregiver burden. Caregivers with financial and economic pressure may experience more burden despite the government providing financial assistance to patients with chronic illness to help the caregivers reduce the burden. Caregivers often provide long-term care for loved ones in their roles as spouses, partners and children. Conflict between career, caregiving responsibilities, and family needs place higher levels of burden on the caregiver, in this study also it is relevent that the caregivers face problems in their career, social life and in financial aspects.

The overall burden level experienced by the respondents after scoring as mentioned in the scale, (68 %) of the respondents experience (Moderate to Severe burden), (18 %) of the respondents experienced Severe burden, (14 %) of the respondents experienced (Mild to Moderate burden), Little to no burden has not experienced by any of the respondents.

Different coping methods used by the respondents

(Kavanagh, 1986) defines the coping methods proposed by **(S.Lazarus and S.Folkman, 1984)** Lazarus and co-workers distinguish eight groups of coping strategies: confrontative coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem- solving, and positive reappraisal, according to these strategies the coping strategies used by the respondents has been assesed in this research,

Problem focused coping has been Used sometimes by a considerable proportion of respondents (9.1 %), half of the respondents used quite a bit (56.8 %), one third of the respondents used greatly (34.1 %).

Escape avoidance coping has been used sometimes by less than one fourth of the respondents (20.5 %), used quite a bit by half of the respondents (52.3 %), used greatly by one fourth of the respondents (27.3 %).

Confrontative coping has been used sometimes by a considerable proportion of the respondents (9.1 %), used quite a bit by half of the respondents (50 %), used less than half of the respondents (40.9 %).

Wishful coping has been used sometimes by a considerable proportion of the respondents (11.4 %), less than half of the respondents used quite a bit (45.5 %), used greatly (43.2 %).

Seeking social support coping has been used sometimes by a considerable proportion of the respondents (15.9 %), used quite a bit by half of the respondents (54.5 %), less than one third of the respondents used greatly (29.5 %)

Positive reappraisal coping has been used sometimes by a considerable proportion of the respondents (11.4 %), used greatly (15.9 %), vast majority of the respondents used quite a bit (72.7 %).

Self-controlling coping has been used by less than one fourth of the respondents, sometimes (20.5 %), used greatly by (22.7 %), half of the respondents used quite a bit (56.8 %).

Relationship challenges faced by the participants

(Nitasha Sharma, 2016) in a study defines ''Alcoholism is considered as a major health as well as a social problem. Often the family members of alcoholics suffer intense psychological, physical and social trauma due to the core drinking problem of the family member''. The findings of the study revealed the problems faced by alcoholics caregivers were in multiple domains viz. physical, psychological and social. While most highly reported were the emotional problems and least reported were the problems of physical violence, in study also it revealed that the caregivers of the alcoholics faces relationship problems with the patient and with others which is also caused by the patient, this study reveals that the caregivers face physical abuse by the alcoholic patient.

Financial constraints faced due to the patient by the participants

(Diksha Tripathy, 2019) defines that alcoholism results Increase in health expenses, legal expenses, vehicle damage expenses are found under influence of alcohol, which leads to bad financial condition. In this study also it is prominent that the financial aspects of the caregivers has been affected largely due to the health expenses, treatment cost, legal expenses, damage made to others by the caregivers.

Participant feeling after admitting the patient in de-addiction centre

The results from the research shows that almost all of the participants feel relaxed and peace after admitting the patient in the de-addiction centre for treatment, even though the participant feels deserted, lonely the participants first and foremost feeling is being relaxed that they don't have to face any problems or new troubles because of the patient, as the patient is in treatment.

Participant knowledge and awareness on de-addiction centre

De-addiction Centre means a centre established under sub-section (1) of section 71 of the Act for treatment and care of persons who are addicted to alcohol or other drugs with the availability of various supporting medical care services or a unit attached to a well-equipped general hospital for the treatment and care

of persons addicted to alcohol or other drugs, which lead to behavioural changes in a person **(Law insider dictionary).**

Through this study it reveals that the participants has lot of stigmas on the de-addiction centre, they are not much aware of the treatment process given to the patient in the de-addiction centre, even after admitting the patient in the centre for treatment the de-addiction centre doesn't provide any information to the participants on the treatment given to the patient in the centre, the participants thinks that the patient will be cured without giving any medications, they think the de-addiction centre cures addiction only by speaking to the patient.

Counseling services provided to the participants by the de-addiction centre

(TJ, 1989) studied on family treatment (MFT) drew three conclusions. First, intervening at the marital/family level with non-alcoholic family members can motivate an initial commitment to change in the alcoholic who is unwilling to seek help. Second, MFT alone, or with individual alcoholism treatment, produces better marital and/or drinking outcomes during the 6 months following treatment entry than methods that don't involve the spouse or other family members, Third, studies of long-term maintenance suggest that BMT with an alcohol and relationship focus may reduce marital and/or drinking deterioration better than individual methods during long-term recovery.

(BE Carter, 1988) defines the importance of family therapy in alcoholism, this study also revals the importance of family therapy, especially with the caregivers who primarily give care to the alcoholic patient, from this study shows that the caregivers of alcoholic patients haven't been offered any counseling in the de-addiciton centres, the de-addiciton centre doesn't provide family therapy to fix the relationship issues in the family.

Challenges in stopping the patient consuming alcohol

The participants face lot of challenges when they tried to make the patient stop consuming alcohol, the participant has been attacked by the patient, the patient started drinking a lot if they try to stop the patient which in turn resluts in not turning up to home and the patient starts dwelling in the streets.

XII. SUGGESTIONS AND CONCLUSION

INTRODUTION

In this chapter the researcher has given suggestions based on the findings in this study for the social work institutions, de-addiction centres, counselors in de-addiction centres, National Social work Institutes, Social Work Institutions, Union government, State government, Ministries for the enhancement of the working with the caregivers of the alcoholic patients.

Suggestions to counselors in de-addiction centres

The counselors of de-addiction centre should also provide proper family therapy or couple therapy along with the counseling for patients based on the needs after assessment, to fix the problems in relationships as almost every patient and caregivers has relationship problems before or after admitting the patient in de-addiction centre as a result of AUD.

Suggestions to de-addiction centres

De-addiction centres should provide proper Counselling and training / psychosocial interventions / psycho-education: to all patients and their care givers, assessed by the trained doctor, should receive Counselling/ psychosocial interventions, as per the clinical needs, as the care givers of the alcoholic patients have been affected a lot as a result of the patients' disease.

Suggestions to National Social Work Institutes and Social Work Institutions

National institutes can offer specialized courses on working with care givers of AUD and SUD patients.

Universities and colleges which provides Social work course can add a separate elective paper for working with care givers of alcohol and substance use disorder patients

Suggestions to State government

According to this study there is no participant attend any support meeting, the state government should conduct, spread awareness, and monitor al-anon and al-teen meetings on regular basis to provide support to the care givers of alcoholic patients.

Suggestions to Union government and Ministries

Union government should initiate and encourage implementing SMART recovery organizations to work for the caregivers of alcoholic and substance use patients

Social work implications

Mezzo level practice - Social workers working in de-addiction centres should focus more on the caregivers of Alcoholic patients.

Social workers can help by using trauma-informed, attachment-informed, and systems-based approaches to direct practice in individual therapy and family therapy with special attention to multigenerational trauma and substance abuse.

The role of the social worker may include providing in-home therapy supporting the caregivers in being more effective with caregivers' supervision, providing structure, and facilitating healthy caring communication. Social workers may serve on multidisciplinary teams to advocate for a caregivers who is adjudicated, abused, or neglected.

XIII. Conclusion

Social workers are the professionals who works for the benefits & welfare of the people of all kind, especially the left out by the society, the social work professional should focus and work more with the caregivers of alcoholic patients, should advocate for them, do research and lobby for them with the government.

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