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Family Burden Among Caregivers of Patients with Epilepsy and Alcohol Dependence

Dr.M.Senthil Psychiatric Social Worker, Dept. of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore-29.

Dr.Manisha Kiran Assoc. Prof & Head., Dept. of Psychiatric Social Work, Ranchi Institute Neuro-Psychiatry & Allied Sciences (RINPAS), Kanke, Ranchi-834006.

ABSTRACT *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 disability2 or those who provide unpaid care to the family members with special 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 present study consisted of 120 samples, among which 60 participants from the caregiver of patients with epilepsy and 60 participants from the caregiver of patients with alcohol dependence. The family burden interview schedule was used to collect the data. Statistical analysis was performed by using the SPSS programme 16.0 version. The result suggested that the caregiver of patients with alcohol dependence have more family burden than caregiver of patients with epilepsy.*

KEYWORDS : Family Burden, Caregiver, Epilepsy, Alcohol Dependence

Introduction

Family caregivers play a major role in providing care giving assistance to ill persons and their families. The effect of stressors on family members caring for an ill person in the family has been referred to as caregiver's burden. Caregiver's burden is a multi dimensional phenomenon reflecting physical, psycho-emotional, social and financial consequences of caring for an impaired family member. Family members are acting as caregivers as the individual in the family of suffering from chronic diseases and continue his treatment at home. In many chronic diseases it places considerable burden for family caregivers who takes the sole responsibility in taking care of chronically ill patients. Caregiver burden in mental illness can either be objective or subjective. Objective burdens are defined as readily verifiable behavioral phenomena, e.g. negative patient symptoms; caregiver's lives disrupted in terms of domestic routine, social activities and leisure; social isolation; and financial and employment difficulties. Subjective burdens comprise of emotional strain on caregivers, ex. fear, sadness, anger, guilt, loss, stigma and rejection. The shift towards community care for patients with mental disease has resulted in transferring responsibility for day-to-day care of patients to their family members, which has lead to profound psychosocial, physical and financial burdens on patients' families. Treadle, (1946) first used this term in relation to the consequences for those in close contact with the psychiatric patient. In the definition of Pai & Kapur, (1981) burden refers to the presence of problems, difficulties or adverse events, which affect the life of psychiatric ill patients and their family members. Some authors have tried to classify burden into two types; subjective and objective burden. Burden of care has two components namely subjective and objective burden as proposed by Hoenig & Hamilton, (1966) Objective burden includes measurable effects such as economic burden, caregivers' loss of work, social and leisure activities, household disruptions such as child care, restrictions on relationships within and outside the family etc. Subjective burden is mainly the psychological sufferings of the caregivers themselves and is experienced by them such as depression, hatred, uncertainty, guilt, shame, embarrassment etc. Provencher, (1996) further classified the objective burden on the family into 'general" and "attributable" objective burden". The former refers to the general consequences on the family; while the latter corresponds to those consequences specifically attributed to the presence of mental illness. Objective burden can be assessed by impartial observation and by administering the interview schedules, while on other hand the subjective burden of families can be inferred from the narrative account of families that are based on their perception of problems (Grad & Simsbury, 1968). In view of the multitude of variables, as mentioned earlier, the management of burden can never be entirely satisfactory and the existing measures remain open to criticisms (Platt, 1985). The World Health Organization's Psychiatric Disability Assessment Schedule (WHO, 1998) explains the terms "psychological and social burden differently. The former is "The subjective experience of discomfort accompanying the awareness of a lasting situation that interferes with one's emotional gratification and sense of personal autonomy and at the same time cannot be readily evaded for ethical, emotional, social or economic reasons". The social burden is explained as "objectively observable disturbances in the functioning of a social group resulting from the presence of a person, or persons, who persistently deviate its norms and cause others to adjust to the deviation, but who cannot be readily dismissed or banished for ethical, emotional, social or economic reasons" (Psychiatric Disability Assessment Schedule, WHO, 1998).

Concept of burden:

The adverse consequences of psychiatric disorders for relatives have been studied since the early 1950s, when psychiatric institutions began discharging patients into the community. According to Treudley (1946) "burden on the family" refers to the consequences for those in close contact with a severely disturbed psychiatric patient. Grad and Sainsbury (1963) and Hoenig and Hamilton (1966) developed the first burden scales for caregivers of severely mentally ill patients, and a number of authors further developed instruments trying to distinguish between "objective" and "subjective" burden. Objective burden concerns the patient's symptoms, behaviour and socio-demographic characteristics, but also the changes in household routine, family or social relations, work, leisure time, physical health.... Subjective burden is the mental health and subjective distress among family members. There are no diverse opinions that psychiatric illness poses various sorts of difficulties upon their caregivers. These difficulties are termed as 'burden of care'. Generally burden has been conceptualized in three ways .Firstly burden has been defined as the extent of workloads and types of care tasks performed & numbers of hours spend performing these tasks. Then it has been termed as caregivers judgment concerning difficulty associated with performing the care tasks. Finally it is described as the "perceived impact of this workload on caregivers' life. There are many literatures suggesting that burden on caretaker depends on various socio-demographic factors, diagnosis & duration of psychiatric illness. It was found that high degree of burden associated with female, old age, low educational level, without employment and who are taking care of younger patients (Caqueo-urizar et al, 2006). More recently, it has been acknowledged that caregivers own characteristics may play a major role in determining how burden and stressful they find their role. These characteristics include such things as gender, availability of support systems, and relationship to patient. As well as the way the caregiver perceives the patients symptoms and his or her attitude and behaviour toward the patient. The model proposed by Maurine & Boyd, (1990) integrates all the factors leading to and mediating both objective and subjective burden. Hoeing & Hamilton, (1966) revised the concept of objective burden that included the effects on financial state, health and leisure of the family. The concept of burden shares characteristics with that of social performance for one person's poor social performance is another person's burden. Both concepts are relative to social expectation, which are likely to vary. Fadden et al. (1987) reported that the existence of burden indicated the breakdown of the reciprocal arrangements that people maintain in their relationships so that some persons have to do more than their fair share. Mills, (1962) found that more than 50% of patients were found as the source of burden and it was reported that patients caused moderate to severe hardship to their caregivers. Recently, Global Burden of Diseases underlined that psychiatric disorders cause 9%of world's total burden, particularly in the developed economics like U.K, U.S.A, and Australia and psychiatric disorders account for 22% of the total burden of diseases, the latter being substantially more than the proportion of the health budget devoted to the prevention and treatment of psychiatric disorders (WHO, 1998). In India, families remain the major ingredient in determining better outcome measures such as ensuring patient compliance, fewer relapses, better acceptance and integration within the family and within the community at large. Positive care giving appraisals equate with better outcomes and vice versa. Unlike the West, family is the key resource in the care of patients with psychiatric illness. Families assume the role of primary care giver for a few reasons. First, it is because of the Indian tradition of interdependence and concern for the near and dear in adversities. Owing to dearth of mental health professionals and the poor infrastructure to provide "community care" in India, more emphasis is placed on the family's role in the care of the patient. Thus having an adequate family support is the need of not only the patient but the clinicians and health administrators. Thus it becomes very important to address care giver needs to ensure adequate family support especially in the Indian context. The present study was to examine the difference in the perception of family burden among caregivers of patients with epilepsy and alcohol dependence.

Methodology

The present study consisted of 120 samples, among which 60 caregivers of patients with epilepsy and 60 caregivers of patients with alcohol dependence. Purposive sampling techniques were used and data collected from outpatient and inpatient department of Ranchi institute of Neuro Psychiatry and Allied Sciences (RINPAS), Ranchi. Patients were selected as per ICD -10 DCR criteria. Tools: Socio- demographic data, GHQ-12, Severity of Alcohol Dependence Questionnaire, Family Burden interview schedule were used.

Analysis and Interpretation

Table-1: Socio demographic variables of caregivers of patients with epilepsy and alcohol dependence

Variable Epilepsy n=60(%)		Caregivers of patients with		X^2/ t	Df	p
		Alcohol Dependence n=60(%)				
Gender of caregivers	Female	39 (65.0%)	40 (66.7%)	.037	1	1.000
	Male	21 (35.0%)	20 (33.3%)			
Marital status of caregivers	Married	59 (98.3%)	55 (91.7%)	2.807	1	.207
	Unmarried	1 (1.7%)	5 (8.3%)			
Relation of caregivers	Spouse	29 (48.3%)	36 (60.0%)	7.761	3	.050
	Parent	22 (36.7%)	9 (15.0%)			
	Sibling	7 (11.7%)	11 (18.3%)			
	Children	2 (3.3%)	4 (6.7%)			
Income of caregivers	Lower	50 (83.3%)	47 (78.3%)	.484	1	.643
	Middle	10 (16.7%)	13 (21.7%)			
Type of Family	Nuclear	52 (86.7%)	51 (85.0%)	.069	1	1.000
	Joint	8 (13.3%)	9 (15.0%)			
Education of caregivers	Primary	17 (28.3%)	20 (33.3%)	.396	3	.960
	Secondary	31 (51.7%)	28 (46.7%)			
	Graduation and above	12 (20.0%)	12 (20.0%)			
Occupation of caregivers	House wife	28 (46.7%)	25 (41.7%)	.913	4	.928
	Private	19 (31.7%)	21 (35.0%)			
	Govt. Service	4 (6.7%)	3 (5.0%)			
	Farmer	6 (10.0%)	6 (10.0%)			
	Unemployed	3 (5.0%)	5 (8.3%)			
Religion	Hindu	42 (70.0%)	46 (76.7%)	.682	1	.536
	Non Hindu	18 (30.0%)	14 (23.3%)			
Age of caregivers (In Years)		40.13 ±11.06	37.58 ±10.51	1.294	118	.198

Table (1) shows comparison of the income of family, type of family, education of caregivers, occupation of caregivers, religion and age of caregivers of persons with epilepsy and alcohol dependent. This table shows that most of the caregivers of epilepsy and alcohol dependence patients were from female gender, married, spouse in relation, lower socioeconomic status, nuclear family, secondary, house wives, and Hindu.

In terms of gender, in caregivers of patients with epilepsy 65.0 % were female and 35.0 were male caregivers whereas in caregivers of patients with alcohol dependence patients 66.7% were female and 33.3 were male caregivers.

In terms of marital status, in caregivers of patients with epilepsy 98.3 % were married and 1.7 were unmarried caregivers whereas in caregivers of patients with alcohol dependence patients 91.7% were married and 8.3 were unmarried caregivers.

In terms of Relation of caregivers, in caregivers of patients with epilepsy 48.3 % were spouse, 36.3 % were parent, 11.7 were sibling and 3.3 were children whereas in caregivers of patients with alcohol dependence patients 60.0% were spouse, 15.0 % were parent, 18.3 were sibling and 6.7 were children.

In terms of Income of caregivers, in caregivers of patients with epilepsy 88.3 % were from lower income, and 16.7 % were from middle income whereas in caregivers of patients with alcohol dependence patients 78.3% were from lower and 21.7 were from middle income.

In terms of Type of family, in caregivers of patients with epilepsy 86.7 % were from nuclear family and 13.3 % were from joint family whereas in caregivers of patients with alcohol dependence patients 85.0% were from nuclear and 15.0 were from joint family.

In terms of Education of caregivers, in caregivers of patients with epilepsy 28.3 % were primary education 51.7 % were secondary education and 20.0 % were graduation and above whereas in caregivers of patients with alcohol dependence patients 33.3% were primary education 46.7 % were secondary education and 20.0 % were graduation and above

In terms of Occupation of caregivers, in caregivers of patients with epilepsy 46.7 % were house wife, 31.7 % were private, 6.7 were govt. service, 10.0 % were farmer 5.0 % unemployed whereas in caregivers of patients with alcohol dependence patients 41.7% were house wife, 35.0 % were private, 5.0 were govt. service, 10.0 % were farmer 8.3 % unemployed

In terms of Religion, in caregivers of patients with epilepsy 70.0 % were Hindu and 30.0 % were Non Hindu whereas in caregivers of patients with alcohol dependence patients 76.7% were Hindu and 23.3 % were Non Hindu

Age of caregivers: The mean age of caregivers of epilepsy was 40.13±11.06 years and the mean age alcohol dependent patients were 37.58±10.51years.

There were no significant different was found in the socio-demographic variable of caregivers

Table-2: Socio demographic and clinical variables of patients of epilepsy and alcohol dependence:

Variable		Group N=60		X^2/ t	df	P
		Epilepsy n=60(%)	Alcohol Dependence n=60(%)			
Patient Education	Illiterate	12(20.0)	5(8.3)	9.619	4	.046*
	Primary	14(23.3)	16(26.7)			
	Secondary	24(40.0)	22(36.7)			
	Intermediate	8(13.3)	6(10.0)			
	Graduate	2(3.3)	11(18.3)			
Patient Occupation	Farmer	15(25.0)	13(21.7)	2.905	3	.420
	Private	29(48.3)	24(40.0)			
	Govt. Service	2(3.3)	6(10.0)			
	Unemployed	14(23.3)	17(28.3)			
Age of patient (In Years)		31.28±6.15	36.51±7.55	4.159	118	.000***
Age of onset (In years)		23.91±8.13	26.86±6.66	2.173	118	.032*
Duration of illness (In years)		7.35±4.26	9.51±5.66	2.365	118	.020*

*Significant p< .05, ***Significant p< .001

Table (2) shows comparison of the patient education, patient occupation, and age of patients, age of onset of illness and duration of illness between patients with epilepsy and alcohol dependent. This table indicates that significant differences were found in patient education, age of patients, age of onset of illness and duration of illness (p< .05. p< .001). There were no significant differences in patient occupation.

In terms of education of patient, in caregivers of patients with epilepsy 20.0 % were illiterate, 23.3 % were primary education, 40.0 % were secondary education, 13.3 % were intermediate and 3.3 % were graduate whereas in caregivers of patients with alcohol dependence patients 8.3% were illiterate, 26.7 % were primary education, 36.7 % were secondary education, 10.0 % were intermediate and 18.3 % were graduate

In terms of Patient occupation, in caregivers of patients with epilepsy 25.0 % were farmer, 48.3 % were private, 3.3 % were govt. service and 23.3 % were unemployed whereas in caregivers of patients with alcohol dependence patients 21.7 % were farmer, 40.0 % were private, 10.0 % were govt. service and 18.3 % were unemployed

Age of patients: The mean age of patients of epilepsy was 31.28±6.15 years and the mean age alcohol dependent patients were 36.51±7.55 years.

Age of onset: The mean age of onset of epilepsy was 23.91±8.13 years and the mean age of onset of alcohol dependent patients were 26.86±6.66 years.

Duration of illness: The mean age of duration of illness of epilepsy was 7.35±4.26 years and the mean age of duration of illness of alcohol dependent patients were 9.51±5.66 years.

Significant different was found in the socio-demographic variable of patient's i.e. patient education, and age of patients, age of onset of illness and duration of illness between patients with epilepsy and alcohol dependent. However there were no significant different found in patient occupation.

Table-3: Comparisons of scores of family burden scale between caregivers of patients with epilepsy and alcohol dependence:

Family burden Scale	Group N=60		**t Value (*df*=118)**	P
	Epilepsy n=60	Alcohol Dependence n=60		
	Mean±S.D.	Mean±S.D.		
Financial burden	7.91±2.30	10.23±3.04	4.697	.000***
Disruption of routine family Activities	6.73±1.82	8.61±2.50	4.710	.000***
Disruption of family leisure	6.30±1.62	6.75±1.80	-1.431	.155
Disruption of family interaction	6.01±1.86	8.53±3.63	4.774	.000***
Effect on physical health of others	2.36±.88	3.71±3.75	-2.714	.008
Effect on mental health of others	2.33±1.00	3.63±2.81	3.375	.001**
Family burden Total	31.60±7.06	38.03±7.45	4.852	.000***

**Significant p < .01, ***Significant p< .001

Table (2) shows comparison between caregivers of patients with epilepsy and caregivers of alcohol dependence on total score and domains of family burden scale. It reveals that caregivers of alcohol dependence patients had scored significantly high on financial burden, Disruption of routine family activities, Disruption of family interaction, Effect on physical health of others, and Effect on mental health of others (p < .01. p< .001). This result suggest that caregivers of patients with alcohol dependence were having more financial burden, disruption of routine family activities, disruption of family interaction, effect on physical health of others, and effect on mental health of others compared to caregivers of patients with epilepsy. It also reveals that caregivers of alcohol dependence patients had scored significantly high on family burden total score (p<.001). There were no differences between these two groups on Disruption of family leisure of family burden scale.

Discussion

Discussion of Methodology:

This study was conducted at the Ranchi Institute of Neuro-Psychiatry and Allied Sciences, Ranchi. It was a cross sectional study about the family burden in the caregivers of individuals with epilepsy as compared to the caregivers of individuals with alcohol dependence. The aim of the study was to assess the family burden in the caregivers of individuals with epilepsy as compared to the caregivers of individuals with alcohol dependence. The present study was conducted among total respondents of 120 samples, consisting of 60 caregivers of individuals with epilepsy and 60 caregivers of alcohol dependence, those who are willing to participate in the study and inclusion and exclusion criteria have been included in the study. The socio demographic data sheet had been used for collecting socio demographic details of the caregivers of individuals with epilepsy as compared to the caregivers of individuals with alcohol dependence. To assess the alcohol severity of the patient, the alcohol severity index scale was applied. For assessing the family burden, family burden scale was used.

Discussion of Results:

Socio-Demographic Variables:

In the present study, the sample size was 120, out of which 60 were caregivers of individuals with epilepsy, and 60 were caregivers of alcohol dependence. In the present study majority of caregivers were female gender in both group such as epilepsy [*n*=39 (65.0%)] and alcohol dependence [*n*= 40 (66.7 %)], majority of the caregivers were married in both group such as epilepsy [*n*=59 (98.3%)] and alcohol dependence [*n*= 55 (91.7 %)], majority of the caregivers were spouse in both group such as epilepsy [*n*=29 (48.3%)] and alcohol dependence [*n*= 36 (60.0 %)], majority of the caregivers from lower socio-economic status in both group such as epilepsy [*n*=50(83.3%)] and alcohol dependence [*n*=47(78.3%)], majority of the caregivers were from nuclear family in both group such as epilepsy [*n*=52(86.7%)] and alcohol dependence [*n*=51(85.0%)], and majority of caregivers were educated up to secondary in both group such as epilepsy [*n*=31 (51.7%)] and alcohol dependence [*n*=28 (46.7%)]. In this study, maximum numbers of caregivers were married women and housewife. Caregivers of epilepsy 33(55.0) were housewife's and Caregivers of alcohol dependence 39(65.0) were housewife's. Most of the caregivers were from Hindu religion in both groups such as epilepsy [*n*=42(70.0%)] and alcohol dependence [*n*=46(76.7%)]. The similar kinds of studies were done by Samira (2012)**.** The mean age of caregivers of epilepsy patients was 40.13±11.06 years and mean age of caregivers of alcohol dependence 37.58±10.51 year. The majority of patients were educated up to secondary in the both group such as epilepsy [*n*=24(40.0%)] and alcohol dependence [*n*=22 (36.7%)]. The majority of caregivers were doing private job in the both group such as epilepsy [*n*=29 (48.3%)] and alcohol dependence [*n*=24 (40.0%)]. The current study findings matches with previous study done by Folorunsho, et al. 2010. Found that majority of the caregivers are female and close to 40% are mothers. This is similar to a recent report among caregivers of patients with schizophrenia in Nigeria. The cultural belief that men should work, and in most cases they are the bread-winners, may have shifted the responsibility of caring for the sick to the women. Whereas epilepsy patients mean age was 31.28±6.15 years and alcohol dependence patients' mean age was 36.51±7.55 years and mean age of onset of taking alcohol was a 31.86±8.45 year. Result also revealed that the age of onset epilepsy patient's illness was 23.91±8.13 and mean age of onset of alcohol illness was 26.86±6.66 years. Result also revealed that the mean duration of epilepsy patient's illness was 7.35±4.26 and mean duration of taking alcohol was 9.51±5.66 years. The current study findings matches with previous study done by Folorunsho, et al. 2010. Found that caregivers the mean age was 43.6 ±9.5 years and mean year of education was 9.7 ±6.0. For the patients; the mean age was 28±13.2, mean duration of illness was 9.5 ±8.2 years and mean seizure-free period was 26.4 ±36.5 weeks.

Family Burden in Caregivers of Patients with Epilepsy and Alcohol Dependence

Family burden has been extensively explored for illnesses like Schizophrenia, Dementia and Cancer by researchers. These families cost incurs in terms of economic hardships, social isolation and psychological strain are referred to as family burden. Review of literature available suggest that family burden in mental and neurological diseases have some common characteristics such as the fact that several cognitive and behavioural symptoms may occur both in brain disorders and schizophrenia and these have been found to be strong predictors of anxiety and depression in patient's relatives because of the inability of the relatives' difficulty in understanding the meaning of some psychiatric and neurological symptoms. Relatives of patients with neurological or mental disorders tend to overestimate a patient's capacity to control symptoms and disabilities.

Chronic illness refers to an altered health state that will not be cured by a simple surgical procedure or a short course of medical therapy. A person with a chronic illness such as alcohol dependence or epilepsy experiences powerlessness causing symptom exacerbation, failure of therapy, physical deterioration despite adherence to the prescribed regimen, the side effects of drugs, and breakdown in the client's psychological stamina. Of late the trend towards caring for chronically ill patients by family members at home is a common phenomenon because of the high costs of institutional care, dissatisfaction with the lack of personalized care in long term settings and the institutions' rejection of some clients as unsuitable due to the nature of their illness or the behaviors that result from the illnesses. The trend of deinstitutionalization places considerable burden for family caregivers who takes the sole responsibility in taking care of chronically ill patients especially in India.

This study examines the differences in the experience of burden between caregivers of patients with epilepsy and alcohol dependence. The aim was to compare the burden on caregivers of epilepsy and to compare the same with caregivers of alcohol dependence. Epilepsy is the most common serious brain disorder and a global problem affecting all ages, races, social classes and countries. It imposes enormous physical, psychological, social, and economic burdens on individuals, families, and countries especially because of misunderstanding, fear, and stigma of epilepsy. Family caregivers also face multiple psychosocial and economic problems. Alcohol is a severe mental health problem associated with health, social and financial burden for a long duration, affecting not only for patients but also for families, other caregivers, and the wider society. Caring for a family member who is having patients with alcohol dependent is an enduring stressor and causes considerable amount of burden. Analysis of burden and coping of family provide for a real world clinical decision, application of research finding, and generation of psychosocial strategies, all geared to promote holistic caring. The ultimate goal of psychosocial care is to maintain and enhance client and family quality of life irrespective of nature of illness.

The present study shows that the caregivers of individuals with alcohol dependence have high on financial burden, disruption of routine family activities, disruption of family interaction, and effect on mental health of others. The current study result also matches with the similar study Caregivers of patients having alcohol dependence and epilepsy experience significant amount of burden just like most of the studies reported in literature. This study result matches with the previous study (Sreeja, 2009) found that caregivers of alcohol dependence experiences more burden such as financial burden, disruption of routine family activities, disruption of family interaction, and effect on mental health of others than Caregivers of epilepsy. It is generally believed that patients of alcohol dependents are disruptive and dysfunctional, and caregivers have more burdens. The present study also reveals that, compared to caregivers of epilepsy, caregivers of alcohol dependents has more burdens in almost all the areas such as financial burden, disruption of routine family activities, disruption of family interaction, and effect on mental health of others.

The current study result also matches with previous study conducted by Paparrigopoulos et al. (2009) found that caregivers exhibited high scores of burden in terms of financial, household, interpersonal relations and parental roles at admission. The presence of alcohol increased the family burden. It is likely that the degree of dysfunction of patient is one of the significant predictor of caregiver's burden, which is similar among caregiver's of patients having alcohol dependence or Epilepsy.

Substance abuse impacts the functioning of the family and the society, and the families of substance abusers experience considerable burden of care compare to caregivers of epilepsy. The study of family burden in substance dependence assumes importance because the profile of the associated factors can both influence the outcome of the problem, and be useful in designing and planning interventions to help the families cope with substance dependence. The traditional family in India is the joint family. It is a group with several family subunits living in separate rooms of the same house (Bhushan, 2006). Substance abuse related family burden is important for India and other developing countries because joint family is a more common pattern. Also, it assumes greater relevance because of the needed emphasis on developing community mental health services under the primary health care and community participation (NMHP, 1982). The aim was to focus not only on the treatment of the patients, but also to meet the needs of the caregivers. Similar approach has been used successfully in other psychiatric disorders, especially schizophrenia (Scazufca, 1998). A study done by Shyangwa, (2008) wives of alcohol dependent individuals experienced severe burden and was reported more often than moderate burden on both subjective and objective assessment. The five principal areas of burden in both the groups were similar i.e. disruption in family relations, finance, caregiver's occupation, patient care, physical and mental health of caregivers. A similar pattern has been reported by other researchers also. Patients of Schizophrenia have disruption in work due to negative symptoms whereas patients of epilepsy are devoid of job because of uncertainty and subsequent fear of seizure activity which means both are in same state in relation to employment (Sreeja, 2009). Studies of caregivers of chronic patients have found levels of burden to be associated with greater severity of illness symptoms and longer duration of illness (Kugoh, 1991). In the current study, the mean duration of illness of alcohol dependence is 7.35 years whereas that of epilepsy is 9.51

years. This difference is significant and it can be attributed to the time of onset of disease, which is early for epilepsy and late for alcohol dependence comparatively. The longer duration of illness of alcohol dependence might have contributed to the increased burden of the caregivers.

Caregiver burden refers to the negative feelings and subsequent strain experienced as a result of caring for a chronically sick person (Natalie et al., 2003). Schizophrenia is a severe mental illness, which is stressful not only for the patients, but also for family members. Numerous studies have demonstrated that family caregivers of persons with severe mental illness suffer from significant stress, experience moderately high levels of burden and often receive inadequate assistance from mental health professionals (Saunders, 2003). Hence caregiver burden, particularly that of closely involved family members such as parents, is important as an outcome measure in mental health care, so as to assess and reduce it for the well- being of both caregivers and mentally ill. Indeed, the measurement of caregiver burden has been shown to enhance worker and administrator awareness of the need to reduce such burden in the health care field in general (Guberman et al., 2003). Results of the study indicate that burden of care and mental health problems are high in caregivers of patients with epilepsy and alcohol dependence this is consistent with the findings of other studies (Platt, 1985 & Rose, 2006). The present study also matches with the previous study that caregivers showed high burden of care and the majority had problems with their mental health. There was highly significant relationship among Burden assessment scale, GHQ and all their subscales i.e., objective burden, subjective burden, somatic symptoms, anxiety and insomnia, social dysfunction and severe depression (Wahida, 2010). The findings of our study also shows that mental health of caregivers remains on stake when they have high level of burden of care, regardless of the fact that alcohol dependence and epilepsy are different disorders in nature. Similar findings have been reported in the previous studies showing that chronic mental illnesses generally affect the overall functioning of caregivers and bring negative consequences on their mental health (Greenberg, 1993 & Laidlaw, 2002). As reported in the previous studies, chronic mental illnesses generally affect the overall functioning of caregivers and bring specific severe consequences on mental health (Afolayan, 2009).

Conclusion

The result suggested that the caregiver of patients with alcohol dependence have more family burden than caregiver of patients with epilepsy. Finally, considering the scarce information available on caregivers of patients with epilepsy and alcohol dependence and the problems in family burden among this population, further research is needed to better understand their needs and identify specific measures to reduce the family burden.

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