

Family Interaction Pattern among caregivers of patients with epilepsy and alcohol Dependence

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Abstract: 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. 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. Statistical analysis was performed by using the SPSS programme 16.0 version. The result suggest that the caregiver of patients with alcohol dependence have poor family interaction pattern than caregiver of patients with epilepsy.

Key Words: Family interaction pattern, caregivers, epilepsy and alcohol dependence.

I. Introduction

Epilepsy is one of the most prevalent neurological conditions and it has no age, racial, social class, geographic, or national boundaries. The impact of epilepsy rests not only on the individual patient, but also on the family and indirectly on the community. The psychosocial problems experienced by people with epilepsy cause greater loss to quality of life (QOL) than the seizures themselves (Austin, 1996; Thompson & Grant, 2001). Besides the impairment in patients' lives, the impact of epilepsy can be seen in families, resulting in burden and decreased caregiver QOL (Sales, 2003). The burden of epilepsy may be due to the physical hazards of epilepsy resulting from the unpredictability of seizures; the social exclusion as a result of negative attitudes of others toward people with epilepsy; and the stigma, as children with epilepsy may be banned from school, adults may be barred from marriage, and employment is often denied, even when seizures would not render the work unsuitable or unsafe. Furthermore, epilepsy is a disorder associated with significant psychological consequences, with increased levels of anxiety, depression, and poor self-esteem compared with people without this condition. Due to having epilepsy to an individual a number of social problems use to arises such as interpersonal conflicts and rejection surface later in life, leading to strained relations. Over a period of time, this leads to feelings of helplessness, hopelessness and worthlessness, often driving the person to the extreme step of suicide or running away from home. The combined effects of epilepsy on the family, the school and in the workplace have a significant impact on the psychosocial functioning of the patient. The family's reactions vary from mixed feelings of overprotection, to rejection, to using the patient as a scapegoat. Emotional responses include horror, guilt, anxiety, sadness, worry, confusion, depression and even avoidance. These reactions lead to various behaviours such as overindulgence, poor monitoring, sibling jealousy and decreased parental expectations. Further, these cause disturbed family dynamics, leading to guilt and concealment, adoption of a sick role, dependence and low self-esteem. The emotional adjustment and coping strategies for these problems thus begin with the individual and extend to the family, acting as major stressors. These behaviours and limited coping patterns lead to changes in personality, apart from the illness itself. Such personality problems coupled with the disease process and medication lead to difficulties in adjustment in interpersonal areas, education, employment and family life. This results in decreased productivity of the person, both in financial and other areas. The patients are already struggling with seizure problems and must face other difficulties as well, which only serves to aggravate the situation (Hanneke, 2008).

Once people have been diagnosed as "epilepsy patients," that is, persons who have had at least two epileptic seizures, they are most probably being treated by a medical specialist, a pediatrician or a neurologist, and antiepileptic drugs (AEDs) will be prescribed and expected to be properly used.

The medical specialist's efforts are directed primarily at the achievement of seizure control. It is often believed that doctors in charge also are providing care for psychosocial problems. One may wonder whether that

is done or is done adequately. From a pilot study (Ravnik, 1997) it appeared that medical files contained little information regarding this domain. Knowledge and adequate support in this area are important because these psychosocial sequel largely determine what it means for the person concerned “to have epilepsy,” even after complete seizure control has been achieved. For the sequel of a condition such as epilepsy are determined not only by the epilepsy itself, but also, and perhaps even more, by the meaning ascribed to the condition by the patient's social environment (Suurmeijer, 1995). In addition to the direct effects epilepsy can have on the daily functioning of people with epilepsy, (prejudiced) attitudes, stereotypes, and behaviors encountered in society both from lay people and professionals (for example from close relatives, friends, neighbors, but also from colleagues, teachers, employers, or physicians) can be more disabling than the seizures themselves and will strongly burden their life. To improve their opportunities to participate fully in society, and consequently, to maintain or improve their daily functioning and position in society, it is necessary to change the way society views epilepsy and treats the people who have it.

Differently put, the general assumption underlying the medical model is that the disease process itself primarily determines psychosocial distress. A worse clinical course is assumed to result in greater psychosocial upset and stress over time. Conversely, a benign course of epilepsy should be associated with levels of psychosocial functioning that do not differ significantly from those of the period before illness. The social science model posits that a set of causal influence factors on adjustment processes in chronic disease (i.e., epilepsy) is located in the social environment of the patient and determines the outcome of short- and long-term adjustment processes. Therefore, in addition to the disease process itself and in accordance with the so-called biopsychosocial model, a supportive environment is considered a second major determinant of the psychosocial status of the patient. Because the consequences are more far-reaching than only the physical aspect, it is obvious that not only aspects in the “physical domain” should be assessed and evaluated but also those of other life domains such as emotional functioning, role activities and social functioning, health perceptions, and general satisfaction with life (Bergner, 1989 & Wiener, 1975). Basically, this argues for a multidimensional approach to the consequences of epilepsy. The “quality of life” (QoL) construct was introduced to assess and evaluate more comprehensively the outcomes or effects of (chronic) illness and medical interventions.

The impact of alcohol problems on family members of the alcohol dependence individuals is widespread; virtually it can penetrate into every area of life, e.g., physical and psychological health, finances, employment, social life and relationships. Alcoholism is a major public health problem around the world (WHO, 2010). The magnitude of the problem in our country is considerable given that India has the second largest population in the world, with 33% of its population consuming alcohol (Gururaj, 2006). It is also a matter of concern that the annual rise in consumption is substantial according to the latest report by World Health Organization (WHO, 2010). Traditionally, studies on problems associated with alcohol have focused on the individual consuming alcohol. In recent times however, concerns about the wider impact of alcohol consumption have increased (WHO, 2010) and have received some attention in research. Despite this, there is a striking paucity of studies on the impact on spouses in psychiatric literature; though it has been reported in public media (WHO, 2010).

Alcoholism is considered as an ongoing stressor, not only for the individual, but for family members as well (Steinglass, 1981). Spouses are particularly affected given the intimate nature of their relationship and the constant exposure to the behavior of the alcoholic (Hurcom, 2000). The negative social consequences of alcohol consumption and stressful life events may trigger psychological, biological, behavioral responses, which interact to diminish the individual's ability to adapt leading to emotional distress reactions and thereby increasing the likelihood of psychological problems (Kahler, 2003). Spouses of alcoholics are known to be exposed to high rates of domestic violence, which could be physical, verbal or sexual (O'Farrell, 2000 & Gil-González, 2006) Low marital satisfaction, (Epstein, 1997 & Halford, 1993) maladaptive coping skills (Orford, 1975 & Chandrasekaran, 1998), and poor social support (Bhowmick, 2001), in addition to economic burden (Mphi, 1994) and social stigma, are the other major issues among the spouses. Though significant levels of psychological distress seem to be apparent from such factors, surprisingly, very few studies have specifically explored this, either in Western or Indian research. Those studies, which have looked into these factors have found high rates of psychiatric morbidity, (Finney, 1983 & Homish, 2006) especially mood and anxiety disorders in the spouses. With psychological well-being comprised, spouses are likely to cope less efficiently, thereby adversely affecting their social and functional roles as a mother (Johnson, 1995), sister, homemaker etc., as well as impacting the family harmony (Suman, 1995). Understanding and addressing the mental health issues of spouses of alcoholics will not only decrease their burden, improve their coping skills and overall quality-of-life, but is also likely to have a bearing on the treatment and outcome of alcoholics (McCrary, 1991 & Suresh Kumar, 2007).

Alcoholism and substance dependence problem no longer remains a source of problem limited not only to the alcohol dependence person; rather it usually becomes a continuous source of stress and suffering to all those people who are closely associated with the alcohol dependence person especially to the alcohol dependence spouse. Problematic alcohol use can have a particular impact on the family, its structures and functions. Alcohol dependence has been regarded as family and social disease because often causal factors of alcoholism are embedded in the family systems of the dependent individuals. Alcoholism has excessively negative effects on the marital lives of the people with alcohol dependence. Spouses of alcohol dependent persons may have feelings of hatred, self-pity, avoidance of social contacts, may suffer exhaustion and become physically or mentally ill. Very often the spouse has to perform the roles of both parents. Family responsibilities shift from two parents to one parent. As a result, the non-alcoholic parent may be inconsistent, demanding, and often neglect the children. Having financial difficulties is another issue that families of alcoholics have to deal with. The family may have to give up certain privileges because of the large amount of money spent on alcohol and also possible joblessness. Now from many researches it was found that family and marital problems often start because of alcoholism, but spouses and children of alcohol dependent individuals may contribute to the drinker's habit and make it worse.

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 led to profound psychosocial, physical and financial burdens on patients' families.

II. Scope And Objectives

The presence of individual with epilepsy and individual with alcohol dependence in the family affects various aspect of family, like leisure time activities, family and social relationship and finances. Presence of individual with epilepsy and alcohol dependence creates problems not only to the person who is suffering from epilepsy and person who takes alcohol but their immediate family members too. Prolonged epilepsy attack and alcohol intake can become a threat to the socio-occupational repertoire of the family members. Family's all functioning be the necessary or secondary, can become inadequate or inappropriate due to this problem. Family's important functioning like interpersonal relationship; general family atmosphere may become pathological because of this problem. Hence the present study will help us in formulating family intervention, to improve the family functioning, to reduce the care givers burden and also to improve their quality of life of caregivers of both groups.

The present study was to examine the difference in the perception of family interaction pattern, family burden and quality of life among caregivers of patients with epilepsy and alcohol dependence.

III. Methodology

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. Purposive sampling techniques were used and data collected from outpatient and inpatient department of RINPAS, Ranchi. Patients were selected as per ICD -10 DCR criteria. The both groups were age and sex matched. Tools: Socio-demographic data, GHQ-12, Severity of Alcohol Dependence Questionnaire and Family Interaction Pattern Scale.

IV. Results

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

Variable		Caregivers of patients with		X ² / t	Df	p
		Epilepsy n=60(%)	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±10.51 years.

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

Table-2: Socio demographic and clinical variables of patients with 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 interaction pattern scale between caregivers of patients with epilepsy and alcohol dependence:

Family Interaction Pattern Scale	Group N=60		t Value (df=118)	P
	Epilepsy (n=60)	Alcohol Dependence (n=60)		
	Mean±S.D.	Mean±S.D.		
Reinforcement	27.81±4.00	32.90±6.09	5.401	.000***
Social support system	29.36±3.93	35.36±5.60	6.785	.000***
Role	62.55±9.52	65.01±12.62	-1.208	.229
Communication	62.20±10.29	66.33±13.42	1.893	.061*
Cohesion	30.38±6.94	33.85±5.59	3.013	.003**
Leadership	32.01±6.45	35.86±5.60	3.491	.001**
Total	2.44±30.06	2.69±36.81	4.139	.000***

*Significant $p < .05$, **Significant $p < .01$, ***Significant $p < .001$

Table (3) shows comparison between caregivers of patients with epilepsy and caregivers of alcohol dependence on total score as well as various domains of Family Interaction Pattern Scale. It reveals that the caregivers of alcohol dependence patients had scored significantly high on reinforcement, social support system, communication, cohesion, leadership and total score of family interaction pattern scale as compared to caregivers of epilepsy ($p < .05$, $p < .01$, $p < .001$), which indicates that caregivers of patients with alcohol dependence were poor in reinforcement, social support system, communication, cohesion and leadership compared to caregivers of patients with epilepsy. There were no differences on role of family interaction pattern scale between the two groups.

IV. Discussion

Discussion Of Sociodemographic 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 socioeconomic 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 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.

Discussion Of Family Interaction Pattern In Caregivers Of Patients With Epilepsy And Alcohol Dependence:

Families with alcohol dependent member/s have some uniqueness in terms of interpersonal relationship style and quality and general climate of the family. Earlier Steinglass (1981) postulated a life history model to understand how these families get along with problematic drinking behavior of their fellow member/s or how family system in general reaches a the 'homeostasis'. He found that in those families chronic alcoholism to one or more members tends to produce distortions in the normative family life cycle. The family is an example of a dynamic system that changes over time as membership changes, individuals change and develop, relationships change, and the family's context changes. A family system is interpretable only when its many multiple components are understood-the multiple components include the individual family members, the relationships between them, the family's relationships with its ecological context, the family's history (multigenerational and experience of events), and the host of internal and external forces for developmental change. Chronic alcohol dependence influences the entire family system and its important functions and as per family systems model an individual's maladaptive behavior (e.g., alcohol abuse) reflects dysfunction in the system as a whole (Van Wormer, 1995). Though all family members are affected by chronic alcoholism to one or more members but in case of married people spouses are found to be at the receiving end in most cases. Alcohol has a major effect on the family; the individual with alcohol dependent have extensive problems in their marriage and families, including more arguments, child and spouse abuse and violence. A series of escalating family crisis may bring a catastrophic disturbance of the family system's structures and functions. Frankenstein et al. (1985) showed that alcohol dependent individuals, after having alcohol tend to get involved in arguments and conflicts with their family members and the longitudinal interactional pattern between those people and their family members tend to become strained. Earlier Gorad (1971) examined areas like marital interactional dynamics, roles, expectations and patterns, especially in relation to alcohol dependence of married males, show a high degree of blaming, competition for dominance, responsibility avoidance by those addicted persons and presence of negative emotion and affect in the interactional and communicational pattern between alcohol dependent persons' and their family members. He also found that in alcoholic families both the alcohol dependent person and his spouse are highly competitive and less cooperative to each other than normal families. Rychtarik et al. (1989) had found that married males with dependence to alcohol tended to present their marriage in an unrealistically favourable manner and report that drinking has not caused impairment in their marriages, whereas their spouses would report significant marital discord as well as faulty interaction between them and their alcohol dependent husbands. The poor family interaction and family support can have deep rooted impact on the prognosis of alcohol dependence syndrome which was seen by previous researchers (Suman&Nagalakshmi, 1995; Akhito et al., 2003).

In present study, it was observed that caregivers of alcohol dependent individuals' have problems in all areas of '*family interaction pattern measuring instrument*', i.e. Family Interaction Pattern Scale (FIPS) (Bhatti et al., 1986) except in the domain of role. The present study indicates that as per caregivers' opinion significant dysfunction has been prevailing in various areas pertaining to family interaction pattern in the families with persons with alcohol dependence. The present study in this way also consistent to previous studies that in alcohol dependent families' interaction pattern is either erroneous or inadequate in comparison to epilepsy families. In the present study author had seen that caregivers of patients with alcohol dependent had scored significantly higher in almost all the domains of Family Interaction Pattern Scale such as reinforcement, social support system, communication, cohesion, leadership and total scores than the caregivers of patients with epilepsy. This phenomenon could be explained by the rationale that these people are not getting adequate and desirable support from their family members and this way their expectations from family members tend to remain unfulfilled which might have caused this difference. In those families several family problems that are likely to co-occur with alcohol dependence, e.g., incidents of violence, conflict and low relationship satisfaction, economic and legal hassles, and under care of children, communicational problems, shrinking of social networks, etc. Communication in such family may be characterized as highly critical, involving considerable amounts of nagging, judgments, blame, complaints, and guilt (Halford&Osgarby, 1993). Families of individuals with alcohol dependent are often characterized by conflict, chaos, communication problems, unpredictability, inconsistencies in messages to children, breakdown in rituals and traditional family rules, emotional and physical abuse (Connors et al., 2001).

In present study more or less same kind of picture has been observed, as there was a significant difference in the scores in various sub-areas of Family Interaction Pattern Scale (Tool used for measuring family interaction) between the caregivers of patients with alcohol dependent and caregivers of patients with epilepsy. The present study findings suggest that caregivers of patients with alcohol dependent has poor cohesion and expressiveness also matches with the previous study done by (Barry & Fleming, 1990) alcohol dependent with a family history of alcoholism reported significantly less cohesion and expressiveness, and more conflict in their

present families than did either non-alcohol dependent with a family history of alcoholism or non-alcohol dependent with no family history of alcoholism. The normal individual who grew up in alcohol dependent families reported present family relationships similar to non-alcohol dependent with no family history of alcoholism. Results suggest a family history of alcoholism alone was not associated with differences in perceptions of present family relationships. The findings of this study raise questions about the general perception that individuals who grew up in alcohol dependent families experience more family dysfunction in adulthood. The presence of two factors together—family history and alcohol problems in the subject—produced the perception of family dysfunction. It is widely held as true fact that chronic as well as problematic drinking of alcoholic beverages is a causal element of marital problems, dissolution or truncation of marital relationship, family problems in the forms of poor family functioning in various important areas, e.g., communication and interpersonal relationship areas, role performance, consolidation of the family as a well-functioning and fulfilling unit and ignorance to various needs of individual family members (Halford&Osgar 1993; Marshal, 2003; Floyd et al. 2006), So the present study result also matches with this study result. Family problems and conflict serve to evoke, support, and maintain drinking behavior. Conflict between two members of the family system may be displaced onto a third party, issue, or substance such as alcohol. Alcoholism can be a coping mechanism for the alcoholic and the family to deal with dysfunctional pattern to deal with dysfunctional pattern and relationship and in this way is a symptom of pathological styles, rules, and patterns of alcohol use (Steinglass, 1981). Ellis (2000) found that epilepsy may cause high levels of psychosocial difficulties for all family members, including stigmatization, stress, psychiatric morbidity, marital problems, poor self-esteem and restriction of social activities. It also suggest that the family environment may be an important intervening factor between the condition and the outcome for the family unit, and a number of family factors are reviewed which have been suggested to mediate this relationship, with recommendations being made for their use in intervention studies.

Findings of the present study

- Most of the caregivers of patients with epilepsy and alcohol dependence were from female gender, married, spouse in relation, lower socioeconomic status, nuclear family, secondary education, house wives, and Hindu religion. There were no significant different was found in the socio-demographic variable of caregivers i.e. Income of the family, type of family, education of caregivers, occupation and age of the caregivers in the both groups.
- Significant different was found in the socio-demographic variable of patients of both groups i.e. patient education, age of patients, age of onset of illness and duration of illness between patients with epilepsy and patients with alcohol dependent. However no significant different was found in patient occupation.

Comparative findings between groups

- The caregivers of patients with alcohol dependence had scored significantly high on reinforcement, social support system, communication, cohesion, leadership and total score of family interaction pattern scale as compared to caregivers of patients with epilepsy. It suggests that caregivers of patients with alcohol dependence were poor in reinforcement, social support system, communication, cohesion and leadership compared to caregivers of patients with epilepsy. There were no differences found on role domain of family interaction pattern scale between the two groups.

VI. Conclusion

In summary, the present study found that the caregivers of patients with alcohol dependence had followed poor family interaction than caregivers of patients with epilepsy. Although the caregivers of patients with alcohol dependence showed significant amount of problem in family interaction compared to caregivers of patients with epilepsy, but this study also found and tells that caregivers of patients with epilepsy also experienced some amount of problem in all the domains of family interaction, so these results reinforce the importance of taking care of both the caregivers such as caregivers of patients with epilepsy and alcohol dependence. Finally, considering the scarce information available on caregivers of patients with epilepsy and alcohol dependence and the problems in family interaction, further research is needed to better understand their needs and identify specific measures to improve their family functioning.

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