*International Research Journal of Social Sciences*_____ ISSN 2319–3565
Vol. **6(8),** 23-26, August **(2017)** *Int. Res. J. Social Sci.*

Family interaction pattern and abstinence among persons with alcohol dependence syndrome

R. Dhanasekara Pandian* **and Ranganathan M.**
Department of Psychiatric Social Work, National Institute of Mental Health and Neurosciences (NIMHANS, INI) Bangalore-560029, India
vnrpandian@gmail.com

Available online at: www.isca.in, www.isca.me
Received 28th June 2017, revised 9th August 2017, accepted 14th August 2017

Abstract

Alcohol Dependence Syndrome (ADS) is a family disease that affects the family as a whole unit. When affected with an individual's alcohol dependence the family goes through a process of trying to adapt to their new environment and often this results in failure leading to dysfunction. The current study aimed to describe the family interaction pattern of persons with alcohol dependence from India. Following consent, ninety participants and their care givers were interviewed belonging to 3 different groups. The first two groups of patients included respondents who had been seeking treatment at our centre and had either been abstinent or relapsed and the thirds group of respondents comprised of a control group. The relapsed group had a higher level of dysfunction when compared to the abstinent group of patients in terms of their role, communication, cohesiveness, leadership and overall family interaction. The results indicate that families who have a member who is dependent on alcohol have poor family interaction patterns that are known to cause dysfunction. Treatment programmes must include providing services to help the family as a whole which will also indirectly benefit the patient as well.

Keywords: Alcohol Dependence Syndrome, Dysfunction, family, family interaction pattern.

Introduction

Family caregivers in India play an important role in the treatment and recovery of the person with mental illness[1]. Patients live with their family members who are involved in their care giving[2]. Research so far has examined family and the family process as a causal entity that affects the client's substance use[3]. Substance dependence is considered as a family disease[4] resulting in significant amount of burden[5] and it has far reaching repercussions on the family such as frequent marital conflicts and breaking away of the marital bonds. As a result of the person's alcohol dependence, the family system as a whole tries to establish a new homeostasis and in attempting to do so, the family most often turns to be dysfunctional[6,7]. Having understood that families of persons with alcohol dependence are known to be dysfunctional, the present study was an attempt to describe the family interaction pattern of patients diagnosed with Alcohol Dependence Syndrome (ADS) attending a tertiary mental health centre in Bangalore.

Methodology

Ethical statement: The ethical approval for this study was obtained from the institutional Human Ethics Committee. The participants were explained about the study and its procedures and a written informed consent was obtained from all the respondents. A descriptive research design was adopted to compare the family interaction pattern of persons who are abstinent, persons who are relapsed and normal subjects.

Setting and participants: The study was carried out at the Centre for Addiction Medicine (CAM), Department of Psychiatry, NIMHANS, Bengaluru, Karnataka, India. Male patients aged ≥30 years to 55 years; diagnosed with ADS as per the International Classification of Diseases (ICD-10)[8] not using any other substance (except nicotine), married and living with the family since the last 5 years were included. Persons with co-morbid or unstable medical or neurological conditions, unmarried or separated were excluded. A total of 90 patients were recruited. Socio-demographic details were collected and the Family Interaction Pattern Scale[9] was administered to assess the interaction pattern of the families of persons with alcohol dependence syndrome. i. Abstinent group: persons who are diagnosed with ADS as per ICD-10 criteria and are abstinent from alcohol since the past six months after receiving detoxification at the centre. ii. Relapsed group: persons who was diagnosed with ADS as per the ICD-10 criteria and stopped using alcohol at least for a month but have relapsed after utilizing the detoxification treatment facility. iii. Control group: 30 normal subjects (teetotalers) with comparable age and years of education to the study group formed the control group. Control group subjects did not have history or family history of alcohol dependence syndrome or mental illnesses.

Data collection and analysis: data was collected from the 3 groups of patients using a questionnaire. After the data was collected it was entered into the Statistical Package for Social Sciences Software (SPSS). Mean and standard deviation was calculated for socio-demographic variables and Analysis of

Variance (ANOVA) was carried out to compare the differences among the three groups on Family Interaction.

Results and discussion

Socio-demographic characteristics: The socio-demographic details of the participants are depicted in Table-1. The sample comprised of 90 participants which were divided into 3 groups i.e. abstinent, relapsed and control group. The mean age of the patients who were abstinent was 41.20 years; patients who relapsed were 43.57 years and the control group was 41.67 years. Analysis of variance revealed that there is no difference on the age and years of education among the three groups making them comparable. The mean age for age of initiation of alcohol use was 23.83 ± 5.96 in the abstinent group and 24.20 ± 7.11in the relapsed group.

Family interaction pattern of persons with alcohol dependence syndrome: The Table-2 below shows the family interaction pattern of the three groups (i.e. abstinent, relapsed and the control groups) on the 6 domains of the family interaction pattern scale. The FIPS mean total score of the relapsed group was 226 and the abstinent group was 229.67. Whereas the same in the comparative normal group was only a mean of 144.23. The difference between all the three groups assume statistical significance at $p<0.05$ level. Analysis using ANOVA revealed that all the three groups differed statistical significance at $p < 0.05$ level on all six sub scales dealing with the sub-factors of reinforcement, social support, role, communication, cohesiveness and leadership. The difference between the groups within the domains of the family interaction pattern scale was analyzed using the student-Newman keuls procedure. The control group was found to be significantly different from both the abstinent and relapsed groups on all the domains of the scale. Further on the domains of role, communication, cohesiveness, leadership and overall scores the relapsed group was observed to be significantly different from abstinent group.

Table-1: Socio demographic data of persons with alcohol dependence syndrome.

Variable	Group	Mean ± SD	F	Sig p<0.05
Age	Abstinent	41.20 ± 6.49	1.067	0.348
	Relapsed	43.57 ± 5.94		
	Control	41.67 ± 7.42		
Years of education	Abstinent	10.67 ± 4.59	0.591	0.556
	Relapsed	11.60 ± 3.95		
	Control	10.63 ± 3.03		

Table-2: Family interaction pattern among the groups.

Factors	Group	Mean ± SD	F	Sig p<0.05	Remarks
Reinforcement	Abstinent	19.27±3.46	31.09	0.00	Control group is significantly different from abstinent group and relapsed group.
	Relapsed	19.20±3.90			
	Control	13.60±1.85			
Social support	Abstinent	24.60±8.65	18.30	0.00	Control group is significantly different from abstinent group and relapsed group.
	Relapsed	27.33±10.08			
	Control	15.73±2.10			
Role	Abstinent	55.47±20.70	23.38	0.00	Control group is different from both the groups. Relapsed group is significantly different from abstinent group.
	Relapsed	66.90±22.22			
	Control	35.93±4.60			
Communication	Abstinent	56.80±17.27	39.76	0.00	Control group is different from both the groups. Relapsed group is significantly different from abstinent group.
	Relapsed	67.23±19.05			
	Control	33.17±5.39			
Cohesiveness	Abstinent	33.57±13.05	20.24	0.00	Control group is different from both the groups. Relapsed group is significantly different from abstinent group.
	Relapsed	39.90±15.14			
	Control	20.93±3.87			
Leadership	Abstinent	39.97±11.49	32.47	0.00	Control group is different from both the groups. Relapsed group is significantly different from abstinent group.
	Relapsed	45.43±13.27			
	Control	24.87±2.53			
Total	Abstinent	229.67±68.08	32.16	0.00	Control group is different from both the groups. Relapsed group is significantly different from abstinent group.
	Relapsed	266.00±77.68			
	Control	144.23±16.24			

Discussion: It can be seen that the families of patients with alcohol dependence syndrome differs significantly and are significantly disturbed when compared to the control group which is similar to findings from other studies[9]. Dysfunction in the area of reinforcement was seen in the families of alcohol dependents compared to the normal control families[10].

Social Support on the other hand revealed that the families of alcohol dependents had adequate social support system compared to the normal group subjects. Though having adequate social support, there was a higher level of dysfunction, which meant that they were not able to utilize the support in the form of primary, secondary and tertiary support systems[11]. As the disease of alcohol progresses, the family member mental and emotional defences act to keep the family intact. This reaction results in denying or rationalising the behaviours of the person with alcohol dependence syndrome to peers, colleagues, extended family and others outside the nuclear family. Ultimately, this results in isolation of the affected member and the family as well. Steinglass's recovery theory states that 'the families in the active drinking stage experiencing overriding fear, leads them to see the outside world as threatening. Consequently the family shuts others out of the family system and becomes increasingly isolated'[12].

On the role domain of the scale, it was observed that the families of alcohol dependents had higher role dysfunctions compared to the normal families indicating that the alcohol dependent families have poor role functioning either in terms of role performance, allocation and or prescription. In other words in the alcohol dependent families, the alcoholic husband failed to do his various roles as a husband or father. The wife assumes or is forced to take over the affected individuals role and responsibilities. This leads to faulty role changes, role allocation, role transfers, role disruption and role conflicts[13]. Several studies have reported that there are serious conflicts and role dysfunctions in the families of persons with alcohol dependence syndrome[14,15] which include structural dysfunction, including chaotic or rigid patterns of adaptability and disturbed interaction boundaries[16]. As the alcohol consumption of the individual increases, family members get a realization that they cannot expect responsible behaviour or role fulfillment from the affected member. As the individual steps down from these responsibilities, trust and communication become compromised. This results in the family members to then shift their roles to compensate for the affected member and to keep the family functioning. Spouses frequently become over controlling, taking over responsibilities and leaving the individual emotionally alienated from the family.

The communication patterns in the families of patients with alcohol dependence syndrome were clearly unhealthy as compared to the normal control families. Communication may be distorted, inappropriate or even absent and both verbal and non-verbal communication may be affected, leading to emotional isolation among the family members. This further indicates that the process through which the family members communicate their feelings, emotions and personal views are faulty[9].

Cohesiveness is any family is very important. Families of persons with alcohol dependence had poor family cohesion compared to the normal control families which indicated that the processes adopted by them were faulty. This finding is consistent with the findings of earlier studies conducted in our population[10]. Families of persons with alcohol dependence syndrome are not flexible, have lower levels of cohesion and expressiveness, have a less recreational orientation and experience more conflict than the normal families[14,15,17].

Faulty leadership in the family system can be considered as an alarm signal of a faulty start of the family system and its overall family dynamics. On the leadership domain there was a higher level of dysfunction in the abstinent and relapsed group of patients when compared to the normal control families[9,10,18] indicating that the leadership pattern existing in alcohol dependent families are faulty and that it does not facilitate the growth of these families. The overall family interaction patterns of the relapsed group were more dysfunctional then the abstinent group. On all the domains of the family interaction pattern scale the alcohol dependent group was higher when compared to the normal control group which is indicative of severe dysfunction in their overall family interaction[9,10].

Conclusion

To conclude the results of this descriptive study highlight that the relapsed group had a higher level of dysfunction when compared to the abstinent group of patients in terms of their role, communication, cohesiveness, leadership and overall family interaction. So far treatment usually focuses only on the patients and their well being. There are hardly any studies that address the family component. Future studies could look at providing interventions to enhance family interaction pattern as it has been observed in the present study that the family interaction pattern is found to be dysfunctional when patients relapse when compared to patients that are found to be abstinent. Family members can play an active role in the recovery of a person from alcohol dependence and therefore providing interventions to the family as a whole will help not only the patient but the family as a unit as well.

References

1. Chadda R.K. and Deb K.S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian J. Psychiatry,* 55(Suppl. 2), S299-S309. http://dx.doi.org/10.4103/0019-5545.105555.
2. Chadda R.K. (2014). Caring for the family caregivers of persons with mental illness. *Indian J. Psychiatry,* 56(3), 221-227. http://dx.doi.org/10.4103/0019-5545.

3. Webester Rosemary A., Hunter M. and Keats J.A. (1994). Peer and parental influences on adolescent's substance use: a path analysis. *Int. J. Addict.,* 29(5), 647-57.

4. O'Farrell T.J. and Fals-Stewart W. (1999). Treatment models and methods: Family models. *Addictions: A comprehensive guidebook*, New York: Oxford University Press, 287-305.

5. Mattoo S.K., Nebhinani N., Kumar B.N.A., Basu D. and Kulhara P. (2013). Family burden with substance dependence: a study from India. *Indian J. Med. Res.,* 137(4), 704-711.

6. Miller I.W., Kabacoff R.I., Keitner G.I., Epstein N.B. and Bishop D.S. (1986). Family functioning in the families of psychiatric patients. *Comprehensive Psychiatry*, 27(4), 302-312.

7. Steinglass P., Tislenka L. and Reiss D. (1985). Stability / instability in the alcoholic marriage: the inter relationship between course of alcoholism, family process and marital outcome. *Family Process*, 24(3), 365-376.

8. World Health Organization (WHO) (2007). The ICD-10 Classification of Mental and Behavioural Disorders: diagnostic criteria for research. World Health Organization: Geneva. ISBN 92-4-154422-8

9. Bhatti R.S., Subbakrishna D.K. and Ageira B.L. (1986). Validation of family interaction pattern scale. *Indian Journal of Psychiatry*, 28(3), 211-216.

10. Kumar D. (1996). A comparative study on the family functioning of alcoholic and non-alcoholic employees in an industry. Unpublished M.Phil thesis, NIMHANS Deemed University, Bangalore.

11. Schilit, R. and Gomberg, E.L. (1987). Social support structures of women in treatment for alcoholism. *Health and Social Work*, 12(3), 187-195.

12. Steinglass P., Davis D.I. and Berenson D. (1977). Observation of conjointly hospitalised alcoholic couples during sobriety and intoxication: Implications for theory and therapy. *Family Process*, 16(1), 1-16.

13. Orford J. (1976). A study of the personality of the excessive drinkers and their wives, using the approaches of leary and Eysenck. *Journal of consulting and clinical psychology*, 44(4), 534-545.

14. Jacob T., Ritchey D., Cvitkovic J.F. and Blane H.T. (1981). Communication styles of alcoholic and non alcoholic families when drinking and not drinking. *Journal of studies on alcohol*, 42(5), 466-482.

15. Billings A.G., Kessler M., Gomberg C. and Weiner S. (1979). Marital conflict resolution of alcoholic and non-alcoholic couples during drinking and non drinking sessions. *Journal of studies on alcohol*, 40(3), 183-195.

16. Henderson S.L. and Henderson D.C. (1983). Family therapy in the treatment of alcoholism. *Social work in health care*, 8(4), 79-94.

17. Moos R.H., Bromet M., Tsu L. and Moos B.S. (1979). Family characteristics and outcome of treatment for alcoholism. *Journal of studies on Alcohol*, 40, 78-88.

18. Gorad S.L. (1971). Communication styles and interaction of alcoholics and their wives. *Family Process*, 10, 475-489.