Case Studies of Family Care for Sufferers of Alcoholism in Delta State, Nigeria

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Abstract

This study is aimed at profiling significant causative conditions in terms of alcoholic's family social characteristics and their preferred care option. The sample consisted of 26 sufferers of alcoholism technically diagnosed in government general hospitals by physicians and social workers. Focus group discussions were held separately with 26 families of the sufferers of alcoholism identified through case files by social workers. The results show that, alcoholism problem is mostly associated with families' member(s) of low socio-economic status and low education. Secondly, the loss of a spouse is reported as a significant factor in patients having negative relationships with significant others. Thirdly, family members say that alcoholic member(s) show significant negative relationship with significant others. And family care givers prefer unorthodox ways of treatment options for their member suffering from alcoholism. This form of care involves only chemotherapeutic measures. The implication of this form of preferred care is that, the sufferers of alcoholism have significant probability rate of relapse. Therefore it is suggested that, families be counseled by social workers and physicians to include some form of psychotherapy in their care practices. This will enable a holistic care and extinguish relapse.

Keywords: Alcoholics, Care, Family, Treatment.

Introduction

The negative consequences of the hazardous use of alcohol are well established (Enekwechi, 1984; Ewhrudjakpor, 1995; 2001; Blum, et al., 1993; Gureje, et at., 1992; Room, 1998; W.H.O. 2002; Hammarstrom and Janlert, 2002; Olley, 2009). According to the World Health Organization (WHO) estimates, alcohol accounts for 3.5% of the global burden of disease in terms of disability – Adjusted Life – Years (Murray and Lopes, 1996).

The World Health report (2002), indicated that 4percent of the burden of disease and 3.2% of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries. The 58th World Health Assembly (WHA) held on 25th May 2005 also recognizes that harmful drinking is among the foremost underlying causes of diseases, injury, violence – especially domestic violence against women and children, disability, social problems and premature deaths, associated with mental ill-health. This has serious impact on human welfare affecting individuals, families, and communities and contributes to social and health inequalities in society as a whole. This emphasis is especially on the risk of harm due to alcohol consumption, particularly, in the context of driving a vehicle, at the workplace, inhibiting sexual intercourse, pregnancy and others such as alcohol induced high-risk behaviours like unsafe sex, and criminal tendencies.

Alcoholism is not only a problem to the alcoholic but also to the entire household. The negative consequences of drinking have been documented by several studies (Ewhrudjakpor, 2001, Khlat, Sermat and Lepape, 2004) confirming that it can impair performance as a parent. This relates to parental care, economically, psychologically, socially and infact sexual relationships with the spouse. Implicit in the alcoholic lifestyle is the potential impact on family life, as it can result to substantial mental health problems of family members due to destitution and thought induced depression (Khlat, Sermet and Lepape, 2004).

Past studies which were conducted on alcoholism were limited to psychosocial and cultural factors, epidemiological surveys, health effects of alcohol and, alcohol addiction. This present study is aimed at a survey of family care for sufferers of alcoholism, using case studies of individual families with alcohol addicts.

Methods

Sample

Twenty-six sufferers of alcoholism were selected through the judgmental sampling technique from general hospitals and the social welfare offices in the local government areas headquarters in Delta State. To be selected for the study, the alcoholic had to be an adult and married in the family. The family member suffering from alcoholism must be living in the same residence with the spouse or significant others. And alcoholic family members should be willing to participate in the study. All the identified sufferers had received ICD 9 diagnosis 303.9 of alcohol dependence syndrome. (http://psyweb.com/ICD9/icd9cm.jsp.3/12/2008).

Status in household of discussants means whether the head of the family is a male or female, while the categorization of low/high socio-economic status of discussants is based on their annual income. Discussants with ₦240, 000 ($1,548.39) per annum are low status families. While amounts above this are put in the high status category.

Procedure

Families of alcoholics who volunteered to participate in this study were engaged in a family focus group discussion (FGD) with the researcher. The selection of these 26 participants and the FGD itself took seven months (April 2009 to October 2009). To verify the identified problem drinkers, the patient's case history was examined by certified physicians and social workers. It is important to note here that, in Delta State, there is no specialist psychiatry hospital. Therefore psychiatrists are almost non existent in these General/Central hospitals. It was after the patient's consent was obtained that the family members were contacted by the hospital staff (social welfare officer) to ask whether they were willing to have a discussion with the researcher. Of the 32 care givers contacted, 26 agreed to have the discussion after mutually suitable time and place have been arranged. The remaining 6 were too shy or ashamed to participate in the discussion despite assurances of anonymity. These 26 households were involved in 26 rounds of FGDs consisting of family members ranging from sizes of 5 to 7. This process took about 4 FGDs in a month.

Instrument

The study was conducted using a focus group discussion guide. This was aided by a micro cassette recorder and a jotter to tape record and manually

record the discussions. The guide had items related to source of alcohol, relationship with family members and current treatment practices. The focus group discussion was administered in the same order to family members with the alcoholic present.

The questions contained in the FGD are the 12 items in Table 2 used as a basis for a multidimensional analysis of the result. It is the summary of the discussions of the 26 families that are contained in the multi-dimensional analysis and quantified in frequencies and percentages. This technique is recently adopted to seemingly quantify qualitative data like that of FGD. Hence the findings literally further depicts the summarized quantified discussions.

Results

Table 1: Social Characteristics of Household Heads of Sufferers of Alcoholism (N = 26)

Sex	Status in Household	Marital Status	Family type	Family size (Average)	Socio-econ status	Educational status	Preferred Treatment Option
Male N = 19 X Age = 36.85	Head = 6 Non Head = 3	Married living together = 15 Married not living together = 4	Monogamy = 19	Husband & wife, plus 5 children (7members)	High = 0 Medium = 6 Low = 13	Tertiary institution=3 Primary education = 10 No education = 6	Orthodox = 6 Unorthodox =2 Orthodox plus Unorthodox = 11
Female N = 7 X Age = 27.33	Head = 0 Non Head = 7	Married living with husband = 2 Divorce = 2	Monogamy = 2 Divorce = 2	Husband & wife, mother-inlaw, plus 2 children = 5 members. Woman ,woman's	High = 0 Medium = 0	No education = 7	Unorthodox = 5 0rthodox plus unorthodox

			mother plus 3 children = 5		= 2
Widow = 3	Widow = 3		Woman plus 4 Children = 5	Low = 7	

Key: Orthodox treatment = General / Psychiatric hospitals
Unorthodox treatment = Traditional / Religious healers
Source:fieldwork,2009

Table 2: Multi-dimensional Analysis of the Focus group discussions held with family members of alcoholics (N=26)

S/N	Item	Scale				
		1 Very Low	**2** Below Average	**3** Average	**4** Above Average	**5** Very High
1.	How would you rate the resources of alcohol purchase by user?			**1** *3.85*	**2** *7.69*	**23** *88.46*
2.	How would you rate alcohol usage by users?		**1** *3.85*	**2** *7.69*	**2** *7.69*	**21** *80.77*
3.	How would you rate the cause of user's alcoholic consumption problem	**2** *7.69*	**5** *19.23*	**9** 34.62	**5** *19.23*	**5** *19.23*
4.	How would you rate relationship with wife(s)	**7** *26.92*	**11** *42.31*	**6** *23.08*	**2** *7.69*	
5.	How would you rate relationship with children	**16** *61.54*	**8** *30.77*	**2** *7.69*		
6.	How would you rate relationship with other family members	**18** *69.23*	**8** *30.77*			
7.	How would you rate relationship with office staff?	**8** *30.77*	**4** *15.38*	**14** *53.85*		

8.	How would you rate user's current treatment behaviour?	**8** *30.77*	**16** *61.54*	**2** *7.69*		
9.	How would you rate the use of orthodox treatment methods such as general/psychiatric hospitals?	**4** *15.38*	**21** *80.77*	**1** *3.85*		
10.	How would you rate the use of unorthodox treatment methods such as traditional healers, religious organizations, shamans			**5** *19.23*	**19** *73.08*	**2** *7.69*
11.	How would you rate wife(s) impression about current treatment practices?	**2** *7.69*	**14** *53.85*	**4** *15.38*	**6** *23.08*	
12	How would you rate user(s) perception of the effects of alcoholism on him or herself?			**2** *7.69*	**4** *15.35*	**20** *76.93*

Key: Figures in bold print are frequencies, while the italicized figures are percentages.
Source: Fieldwork 2009

Findings

- Alcoholism problem is mostly associated with families of low socio-economic status and low education.
- Loss of a spouse is reported as a significant causative factor of alcoholism.
- Alcoholics show significant negative relationship with significant others.
- Family care givers prefer unorthodox and mixture of orthodox and unorthodox treatment options for their alcoholic member.

Discussion

This survey of family care for sufferers of alcoholism provides a profile of significant causative conditions, social characteristics and preferred treatment option. In pursuance of this profiling, 26 families with alcoholics were

identified from hospital records in the state, with whom focus group discussions were held. The findings are summarized in tables 1 and 2.

As Table 1 shows, there is a significant positive relationship between low socio-economic status, low education and addiction to alcohol among the 26 families studied. However, 6 of the families were of medium socio-economic status while the remaining 13 were of low social class. This corresponds positively with their educational status. Only 3 families had members with tertiary education, while 10 others had members with primary education, and 13 families had members with no education. This finding corroborates earlier studies (Ohaeri and Odejide, 1993; Hammarstrom and Janlert, 2002; Olley, 2009; Odejide, 2005; and Obembe, 19988). These authors argued that alcoholism is a common feature among the low social and educational status irrespective of where they live whether in rural or urban settlements. The reason most authors gave is that, alcohol consumption, particularly cheap liquor such as 'Ogogoro' Gin' or 'Akpeteshie' or 'Burukutu' or palm wine, are used by people to console themselves and be happy, as a technique of over-compensatory acts.

Against this background, alcoholism is sustained particularly when there is bereavement in the family or worse still, loss of a spouse. This, according to the second finding of this study, is a significant causative factor. Past studies support, this finding (Enekwechi, 1984; Gureje, Obikoya, and Ikuesan, 1992; Ewhrudjakpor, 2001). For instance during the F.G.D, a member of one family puts it thus

> My mummy used to be very religious, but six months after the death of my father, she started declining in church activities, withdrawn and engaged in frequent drinking of dry gin 'ogogoro'. It's a problem, we have tried the church, the hospital, but all to no avail. In fact her market (trade) has been affected due to lack of concern and money meant for the trade has been spent pursuing her treatment.

Other families discussed with (Blum, et al, 1993; W.H.O, 2002; http://www.athealth.com/consumer/disorders/COAfacts.retrieved12/7/2009.10.00pm) made similar statements, which invariably connect bereavement to a cycle of withdrawal-depression-alcoholism.

Cases studied in this report indicated that the cyclical nature of alcoholism reduces significantly their cordial relationship with significant

others such as spouses, children, work colleagues, bosses, and neighbours. The spouse (living) suffers sexual assault or weakening of inhibition, the children suffer from lack of total parenting from both husband and wife. Due to absenteeism from home most of the time, the children lack psychological growth of love and other emotion; there are cases of frequent family violence, while the alcoholic's work suffers due to alcoholism, putting him or her in a confrontational stance with colleagues or their bosses. Neighbours see him or her as clown and laughing stock and this reduces the personality profile of the alcoholics household. At the individual level, alcoholism brings a burden of disease due to a drop in immunity level as a result of loss of appetite for food and increased drive to drink liquor. These reflect in all the discussions with the 26 families. This is summarized in one of the family members statement in response to a question on the nature of the relationship of the alcoholic family member with others. She lamented thus:

> Please, that question has a common answer, everybody knows. First, the wife, me, myself I suffer seriously, because my husband's 'thing' penis is 'gone' (that is sterile), smiles. There are other things my brother (researcher) if he comes home without enough drink that day, my children my self become punching bag, our neighbours laugh at us. Infact when I told my in-laws, they say I made him drunk, so I must live with it, instead of food, he will be looking for drink even around 4.30a.m. My brother (researcher) the problems are too many, may be my children will continue with you, … burst into tears.

The children did continue the lamentations of their father's alcoholism woes. These significant negative effects of alcoholism are not news, other studies (Blum, Roman and Martin, 1993; Obot, 2000; Ewhrudjakpor, 2001; WHO, 2002; and Luginaah and Creseentia, 2003; Khlat, et al., 2004) have identified them. What is novel here, is the approach of family members in the care of their alcoholic members.

Finally, despite all these social characteristics and causative factors of alcoholism identified above, the care of alcoholics by family members suggests that family environment may exert a significant influence on the course of alcoholism. In particular, the FGDs conducted in this study show, that most caregivers prefer in order of priority, unorthodox treatment,

orthodox mixed with unorthodox treatment and lastly orthodox medication. The reason for this is not unrelated to the participant's low educational status which predisposes them to deep rooted cultural beliefs and practices pertaining to abnormal behaviour and psychiatric problems, which is that, abnormal acts or psychiatric problems like alcoholism are products of supernatural or preternatural forces (Enekwechi 1984; Obembe, 1988; Ewhrudjakpor, 1995; Odejide, 2006).

In one of the responses during the FGDs with 26 families, a mother, wife, puts it succinctly, thus:

> The care of alcoholics is a huge burden and task for us (the family) we started by pleading with him (points to the husband), he refused, I reported the matter to family members (extended African family) they rebuffed me, I took him for prayers in a Christian crusade, there was no change, my son took him to the General hospital, no way! Now we are using native doctor medicine (concoctions) and some drugs from the doctor (physician). We still talk and prevent him from associating with people too much. By God's grace, we will be well.

In explaining the attraction of treatment choice in care giving to alcoholics, two conditions of caring, are discernable that is treatment in terms of chemotherapeutic medication and treatment in terms of psychological reassurances in the form of negative or positive emotions and attitudes towards alcoholic(s) in the family. This study has revealed as shown in Table 2, that most families emphasized the treatment option of chemotherapy in the form of unorthodox medication (73.08% of the 26 families). The psychological intervention was absent. This may be due to ignorance of the potency of psychotherapy on the part of family members or lack of psychotherapy services, particularly as there is no psychiatric facility in Delta State. The implication of this is that, sufferers of alcoholism will continue to use in chemotherapeutic measures and may be healthy, partially due to the stigma they will face as a result of shame and inferiority that have a tendency of pushing them to relapse.

Conclusion

It can be inferred from this study that family members suffering from alcoholism come from low socio-economic background, and inadequate education. These conditions facilitate alcoholism. Family members as care givers prefer unorthodox treatment options in terms of employing only chemotherapeutic measures. Therefore getting healthy in anyway is temporary as the psychotherapeutic aspect of care giving is inadvertently missing. As a result of this partial care, alcoholics are prone to high rates of relapse due to the stigma from shame and inferiority complex which the alcoholic suffer from family members, co-workers and neighbours. It is therefore suggested that, families with alcoholic members should ensure that they provide total care for them that includes both chemotherapeutic and psychotherapeutic care.

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