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Between Compassion and Collapse: Alcohol Intake and Mental Health Challenges in Caregivers of Patients with Suicidal Behavior

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ABSTRACT

Introduction: Suicidal behaviour poses significant public health concerns, not only for individuals but also for their caregivers, who often experience emotional distress. Alcohol use as a maladaptive coping strategy are underexplored in caregivers of individuals exhibiting suicidal behaviour .

Method: This observational cross-sectional study was conducted from December 2023 to May 2024 at the Psychiatry Department of Sharda Hospital, Greater Noida. Eighty caregivers of patients with suicidal behaviour were enrolled using a convenience sampling method. Participants were assessed using a self-designed Case Record Form for demographic data, the and the Alcohol Use Disorder Identification Test (AUDIT) for alcohol use patterns. Statistical analysis was performed using SPSS 22.0, with associations analyse d using Chi-Square and ANOVA.

Result: Among 80 caregivers, Alcohol use was identified in 28.8%, with a higher prevalence among male caregivers.

Conclusion: Alcohol consumption are prevalent challenges among caregivers of suicidal patients, underscoring the need for targeted interventions to promote healthier coping mechanisms.

Keywords: *Suicidal behaviour ; Caregivers; Alcohol consumption; Psychiatric care; Mental health.*

1. INTRODUCTION

The role of caregivers in supporting individuals with suicidal behaviour is critical, yet the challenges they face are often overlooked. This burden is further exacerbated by unhealthy coping mechanisms, such as alcohol consumption, which is prevalent among caregivers in stressful caregiving roles. Alcohol use, while often perceived as a temporary escape from stress, may exacerbate existing stigma and impair caregivers' ability to provide effective care, thus creating a vicious cycle of psychological distress and maladaptive behaviour .[1]

Caring for an individual experiencing suicidality takes a heavy toll on the whole family system and can negatively impact both the physical and psychological wellbeing of the caregivers.[2] Globally, alcohol consumption has increased in recent decades, with all or most of that increase occurring in developing countries. Alcohol consumption has health and social consequences *via* intoxication (drunkenness), dependence (habitual, compulsive and long-term drinking), and biochemical effects.[3] In addition to chronic diseases that may affect drinkers after many years of heavy use, alcohol contributes to traumatic outcomes that kill or disable at a relatively young age, resulting in the loss of many years of life to death or disability. There is increasing evidence that, aside from the volume of alcohol consumed, the pattern of the drinking is relevant for health outcomes. [3,4]

This study aims to assess the prevalence and impact of alcohol consumption among caregivers of patients with suicidal behaviour . By identifying the factors contributing to these challenges, this research seeks to shed light on the complex dynamics affecting caregivers and provide a foundation for designing interventions that promote healthier coping strategies

2. METHOD

This study was an observational, cross-sectional study conducted from December 2023 to May 2024 at the outpatient and inpatient departments of the Department of Psychiatry, Sharda Hospital, Greater Noida, Uttar Pradesh.

The study involved caregivers of patients exhibiting suicidal behaviour in their current episode. Caregivers were selected based on specific inclusion and exclusion criteria to ensure the validity and reliability of the data.

The study was initiated after obtaining approval from the Ethics Committee. Written informed consent was obtained from all participants after providing them with a detailed explanation of the study, along with a patient information sheet.

With non-probable convenience sampling technique data collection was done for the duration of 3 months and as per inclusion and exclusion criteria 80 patients were enrolled for the study

The inclusion criteria for the study required caregivers of patients with suicidal behaviour in their current episode. Only adult caregivers were included, and participants with no history of previously diagnosed psychiatric illnesses or previous psychiatric treatment were eligible. No specific exclusion criteria were applied to the study population.

To collect data, the study utilized three primary tools. First, a semi-structured, self-designed Case Record Form gathered demographic and socio-economic information such as age, sex, occupation, marital status, relationship to the patient, education, socio-economic status, income, and type of family,The AUDIT (Alcohol Use Disorder Identification Test), a clinician-administered 10-item scale, screened participants for excessive alcohol consumption.[5]

Participants were recruited from the outpatient and inpatient services of the psychiatry department. Caregivers meeting the inclusion criteria were identified, and a detailed history of the patients was obtained to confirm suicidal behaviour . Caregivers willing to participate were provided with an explanation of the study's objectives and procedures. Written informed consent was obtained before proceeding. The participants were then assessed using the AUDIT to determine patterns of alcohol consumption. Data collection was conducted through face-to-face interviews and self-administered forms.

Data were entered and analyse d using SPSS Version 22.0 and Microsoft Excel 2010. Measures of central tendency and dispersion were used to describe the data, with results expressed as numbers and percentages. Graphical presentations were used for qualitative data.

The Chi-Square test was used to examine the association between variables, and an ANOVA test was applied to analyse differences between two or more quantitative variables. A p-value less than 0.05 was considered statistically significant.

3. RESULT

Table 1: Impact of Demographic Variables on Alcohol Use Severity

Variable	Severity of Alcohol use				P value
	Harmful n (%)	Hazardous n (%)	High Risk n (%)	Low Risk n (%)	
Age Group					
21-30	2 (9.5)	7 (33.3)	11 (17.7)	7 (33.3)	0.442
31-40	14 (66.7)	7 (33.3)	26 (41.9)	10 (47.6)	
41-50	4 (19.0)	5 (23.8)	15 (24.2)	3 (14.3)	
51-60	1 (4.8)	2 (9.5)	8 (12.9)	1 (4.8)	
61-70	0 (0.0)	0 (0.0)	2 (3.2)	0 (0.0)	
Sex					
Female (F)	8 (38.1)	9 (42.9)	26 (41.9)	4 (19.0)	0.281
Male (M)	13 (61.9)	12 (57.1)	36 (58.1)	17 (81.0)	
Religion					

Buddhism	0 (0.0)	1 (4.8)	0 (0.0)	0 (0.0)	0.446
Christian	0 (0.0)	0 (0.0)	1 (1.6)	1 (4.8)	
Hindu	18 (85.7)	18 (85.7)	57 (91.9)	17 (81.0)	
Muslim	3 (14.3)	2 (9.5)	2 (3.2)	2 (9.5)	
Sikh	0 (0.0)	0 (0.0)	2 (3.2)	1 (4.8)	
Relation to Patient					
Aunt (Bhua)	0 (0.0)	0 (0.0)	1 (1.6)	0 (0.0)	0.208
Brother	1 (4.8)	4 (19.0)	8 (12.9)	4 (19.0)	
Father	7 (33.3)	4 (19.0)	12 (19.4)	2 (9.5)	
Father-in-law	0 (0.0)	0 (0.0)	0 (0.0)	1 (4.8)	
Grandmother	0 (0.0)	0 (0.0)	2 (3.2)	0 (0.0)	
Husband	5 (23.8)	4 (19.0)	13 (21.0)	8 (38.1)	
Mother	3 (14.3)	3 (14.3)	13 (21.0)	1 (4.8)	
Roommate	0 (0.0)	0 (0.0)	1 (1.6)	1 (4.8)	
Sister	0 (0.0)	4 (19.0)	2 (3.2)	2 (9.5)	
Wife	5 (23.8)	2 (9.5)	10 (16.1)	1 (4.8)	
Marital Status					
Divorce	1 (4.8)	1 (4.8)	0 (0.0)	0 (0.0)	0.242
Married	18 (85.7)	14 (66.7)	48 (77.4)	14 (66.7)	
Single	2 (9.5)	6 (28.6)	11 (17.7)	7 (33.3)	
Widowed	0 (0.0)	0 (0.0)	3 (4.8)	0 (0.0)	
Family type					
Alone	1 (4.8)	2 (9.5)	2 (3.2)	1 (4.8)	0.873
Extended Family	7 (33.3)	9 (42.9)	22 (35.5)	8 (38.1)	
Joint Family	2 (9.5)	3 (14.3)	13 (21.0)	5 (23.8)	
Nuclear	11 (52.4)	7 (33.3)	25 (40.3)	7 (33.3)	
Education Status					
Graduate	5 (23.8)	8 (38.1)	20 (32.3)	13 (61.9)	0.095
High School	7 (33.3)	1 (4.8)	12 (19.4)	1 (4.8)	
Illiterate	0 (0.0)	0 (0.0)	5 (8.1)	0 (0.0)	
Postgraduate	0 (0.0)	1 (4.8)	0 (0.0)	1 (4.8)	
Primary	1 (4.8)	0 (0.0)	3 (4.8)	0 (0.0)	
Secondary	8 (38.1)	11 (52.4)	21 (33.9)	6 (28.6)	
Occupation					
Business	3 (14.3)	2 (9.5)	10 (16.1)	2 (9.5)	0.994

Clerical	7 (33.3)	5 (23.8)	15 (24.2)	7 (33.3)	
Labourer	1 (4.8)	1 (4.8)	1 (1.6)	1 (4.8)	
Professional	2 (9.5)	5 (23.8)	8 (12.9)	3 (14.3)	
Student	2 (9.5)	3 (14.3)	10 (16.1)	4 (19.0)	
Unemployed	5 (23.8)	2 (9.5)	12 (19.4)	2 (9.5)	

The analysis of various demographic factors in relation to alcohol use severity revealed some interesting patterns, though most of the associations were not statistically significant. For instance, the age group distribution did not show a significant variation in alcohol use severity (p-value = 0.442). However, individuals aged 31-40 years had the highest proportions of hazardous (33.3%) and high-risk (41.9%) alcohol use. Regarding gender, no notable differences were observed between males and females (p-value = 0.281), although males represented a larger proportion in the high-risk and low-risk categories.

Religion did not seem to influence alcohol use severity significantly (p-value = 0.446), with Hindus making up the majority in each severity group. When considering the relationship to the patient, no significant patterns emerged (p-value = 0.208), though fathers (33.3%) had the highest occurrence of harmful alcohol use. Marital status also showed no significant impact on alcohol use severity (p-value = 0.242), but married individuals had the highest proportion in both harmful and high-risk categories.

Family type appeared unrelated to alcohol use severity (p-value = 0.873), with nuclear families being the most prevalent in the high-risk group. Education status showed a near-significant trend (p-value = 0.095), with individuals who had completed high school and secondary education representing a large portion of those with harmful alcohol use. Finally, occupation did not significantly correlate with alcohol use severity (p-value = 0.994), though clerical workers accounted for the highest percentage in the hazardous category.

Table 1: Demographic Factors and Their Impact on AUDIT Scores

Factor	Group	AUDIT (Mean ± SD)	p-value (AUDIT)
Age Group	21-30	13.7 ± 7.8	**0.292**
	31-40	15.7 ± 7.3	
	41-50	16.4 ± 6.2	
	51-60	18.4 ± 6.3	
	61-70	20.0 ± 0.0	
Sex	Female	16.9 ± 6.1	**0.154**
	Male	15.0 ± 7.6	
Religion	Buddhism	12.0 ± 0.0	**0.671**
	Christian	12.0 ± 11.3	
	Hindu	16.1 ± 7.0	
	Muslim	13.4 ± 7.8	
	Sikh	13.3 ± 11.5	
Relation to Patient	Aunt (Bhua)	20.0 ± 0.0	**0.062**
	Brother	14.3 ± 7.8	
	Father	16.8 ± 5.7	
	Father-in-law	4.0 ± 0.0	
	Grandmother	20.0 ± 0.0	
	Husband	14.4 ± 8.3	

	Mother	18.7 ± 6.1	
	Roommate	12.0 ± 11.3	
	Sister	11.5 ± 7.1	
	Wife	17.4 ± 5.4	
Marital Status	Divorce	13.5 ± 3.5	**0.014**
	Married	16.2 ± 6.9	
	Single	13.8 ± 8.0	
	Widowed	21.0 ± 1.0	
Family	Alone	14.7 ± 7.5	**0.908**
	Extended Family	15.7 ± 7.5	
	Joint Family	15.1 ± 7.7	
	Nuclear	16.2 ± 6.5	
Education Status	Illiterate	21.6 ± 2.2	**0.014**
	Postgraduate	7.5 ± 6.4	
	Primary	20.0 ± 3.3	
	Secondary	15.7 ± 6.7	
	High School	18.8 ± 4.5	
	Graduate	13.7 ± 8.2	
Occupation	Business	16.9 ± 6.0	**0.944**
	Clerical	15.0 ± 8.0	
	Farmer	20.0 ± 0.0	
	Labourer	13.3 ± 10.3	
	Professional	14.9 ± 6.8	
	Student	15.8 ± 7.3	
	Unemployed	16.5 ± 6.6	
Locality	Rural	16.1 ± 7.0	**0.508**
	Urban	15.2 ± 7.4	
Total		15.7 ± 7.1	

The table presents demographic factors and their associations with Alcohol Use Disorder Identification Test (AUDIT) scores among caregivers. A higher AUDIT score indicates more harmful alcohol use.

AUDIT scores generally increased with age. Males had higher AUDIT scores (15.0 ± 7.6).

AUDIT scores showed minimal differences across religious groups, with no significant associations. Mothers and grandmothers reported harmful alcohol use

Widowed caregivers had the higher AUDIT scores (21.0 ± 1.0), with a significant association of marital status with AUDIT scores (p=0.014).

AUDIT scores varied across family types, but the differences were not statistically significant.

Illiterate caregivers had the higher alcohol use (21.6 ± 2.2), with education significantly associated with AUDIT scores (p=0.014).

Farmers exhibited the higher AUDIT scores. Urban vs. rural locality did not significantly influence scores.

Analysis shows that stigma and alcohol use were notably influenced by relationships to patients, marital status, and education.

4. DISCUSSION

While our study found no significant demographic predictors of alcohol use severity. Existing literature offers insights that align partially with our findings and highlights areas for further exploration. Caregivers of patients with alcohol use disorder (AUD) often experience a heavy care burden, comparable to that seen in caregivers of schizophrenia patients, which manifests as anxiety, depression, and reduced quality of life (Vadher et al., 2020). [6]

Female caregivers tend to experience higher burdens of care, which might indirectly influence alcohol use severity among caregivers themselves (Vadher et al., 2020). [6]

Moreover, alcohol misuse is often associated with psychosocial adversity, exacerbating stress levels and increasing the risk of suicidal behaviour (Sher, 2006).[7]These relationships suggest a complex interplay between alcohol use, mental health, and caregiver burden.

Our study analyse d the influence of demographic factors on AUDIT scores among caregivers of patients with suicidal behaviour . While the findings indicated some trends, most demographic factors did not show statistically significant differences in scores. This section compares our findings with existing literature to contextualize and interpret the results.

In our study, age did not significantly influence AUDIT scores (p = 0.292). However, individuals aged 61-70 had the highest AUDIT scores (20.0 ± 0.0). This aligns partially with prior research indicating that alcohol misuse is associated with suicidality (McCloud et al., 2004), [8] our study highlights that older caregivers may be more prone to higher alcohol-related risks.

In Contrast, Zahid & Ohaeri (2010) [9] found younger caregivers reported greater distress, suggesting that age-related factors may influence caregiving burdens differently based on the population studied.

Gender differences in AUDIT scores were not statistically significant in our study (p = 0.154). Report that alcohol consumption and its association with suicidal ideation are influenced by gender. While our study did not find significant differences, the observed trends suggest that gender-specific factors may merit further exploration, particularly in the context of stigma and caregiving roles.

Religion did not significantly affect AUDIT scores (p = 0.671), although Hindus had the highest AUDIT scores (16.1 ± 7.0). Literature on the impact of religion on caregiving burden is limited, but cultural norms and religious coping mechanisms may play a role in caregiving experiences, as highlighted in studies from Mediterranean countries (Gonçalves-Pereira et al., 2012).[12]

Marital status was significantly associated with AUDIT scores (p = 0.014), with widowed caregivers reporting the highest scores (21.0 ± 1.0). This finding aligns with prior research highlighting the vulnerability of socially isolated caregivers (McCloud et al., 2004).[8]

Education showed a near-significant association with AUDIT scores (p = 0.014), with illiterate caregivers reporting the highest scores (21.6 ± 2.2). Zahid & Ohaeri (2010)[9] similarly found that lower educational levels were associated with higher caregiver burden.

Neither occupation nor locality significantly impacted AUDIT scores in our study. Farmers reported the highest AUDIT scores (20.0 ± 0.0), but this finding was not statistically significant. Literature suggests that rural caregivers might face unique challenges, but our results did not show significant rural-urban disparities (p = 0.508 for AUDIT)

While our study found limited significant relationships between demographic factors and AUDIT scores, the trends observed align with broader findings in the literature. For example, caregiver distress and alcohol misuse are influenced by individual and contextual factors such as education, gender, and caregiving roles (Zahid & Ohaeri, 2010; [9] Gonçalves-Pereira et al., 2012).[11] Furthermore, prior studies emphasize the role of alcohol use in suicidality (Bae et al., 2015),[10]underscoring the need for AUDIT assessments in psychiatric evaluations (McCloud et al., 2004).[8]

Alcohol use disorders are well-established risk factors for suicidal behaviour (Conner, 2019).[13] Alcohol may contribute to suicidality through mechanisms such as disinhibition, impaired judgment, and exacerbation of depressive symptoms (Pompili et al., 2010).[14] Caregivers of patients with suicidal behaviour often face immense stress, which might increase their vulnerability to harmful coping mechanisms, including alcohol use.

5. CONCLUSION

Caring for an individual experiencing suicidality takes a heavy toll on the whole family system and can negatively impact both the physical and psychological wellbeing of the caregivers.[2] This study highlights a significant positive correlation between internalized stigma and alcohol use severity among caregivers of patients with suicidal behaviour . While demographic factors like age, gender, and marital status did not significantly affect stigma or alcohol use, trends such as higher alcohol use among married individuals and those with secondary education were observed. Caregivers with higher internalized stigma were more likely to exhibit severe alcohol consumption. The findings suggest that addressing internalized stigma could help mitigate alcohol use severity and improve caregivers' mental health.

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