PSYCHOLOGICAL WELL-BEING AND MORBIDITY IN PARENTS OF NARCOTIC-DEPENDANT MALES

CHITTARANJAN ANDRADE
P. L. SARMAH
S. M. CHANNABASAVANNA

SUMMARY

In the description of parental psychopathology in narcotic dependence, emphasis has hitherto largely lain on the identification of addictogenic characteristics rather than on the identification of psychological distress. In an attempt to remedy the situation, we compared the parents of 21 male narcotic dependent patients with an equal number of matched controls. Using the General Health Questionnaire and the Subjective Well Being Inventory, we found the ‘narcotic parents’ experienced more (clinically significant) psychological distress than did controls, and that this impairment was greater in ‘narcotic mothers’ than in their husbands. This distress was an ostensible result of having to cope with the burden of a narcotic dependent offspring. In view of these findings, and considering the poor prognosis associated with this diagnosis, we suggest that management programmes for narcotic dependance include psychotherapeutic intervention directed towards reducing distress experienced by the parents. Possible lines for such intervention are suggested.

In recent years, there has been growing interest in narcotic dependance in social, political and medical circles, partly because of the growing menace of these drugs of abuse, and partly because of their pernicious economic and moral effects on society, and their detrimental psychological, biological and social effects on the abuser. While the need for primary and secondary prevention models for narcotic dependance is undeniable, scope exists for the improvement of the present day tertiary prevention models, i.e., those dealing with the disability occasioned by narcotic dependance.

Hitherto, the focus of tertiary prevention models has been the narcotic abuser and not his family, the members of which are likely to suffer some material and psychological repercussion of the index patient’s disability. In fact, granted the circularity model of family psychopathology (Channabasavanna and Andrade, 1987), it is quite within reason to suppose that psychopathology in the family provokes and maintains drug-seeking behaviour in the patient and vice versa, which likelihood has partly accounted for some workers recommending that the family approach is the treatment method of choice in drug dependance (Wurmuth and Scheidt, 1986). Yet, such tertiary prevention models that have been devised to involve the family have again predominantly focused on the index case, playing down the family’s possible need for psychological succour.

We therefore conducted a study addressing the parents of narcotic dependant males, to assess their possible personality psychopathology the stresses and strains in their marriage and their levels of psychological well-being and morbidity; the last-mentioned is the subject of the present report.
Material and Methods

The experimental group (narcotic parents) comprised the parents of all male narcotic dependant (DSM III) patients identified over a seven month period in the department of psychiatry, NIMHANS. To be included in the study, cases had to additionally fulfill the following selection criteria—

Inclusion criteria
1. Both parents alive and living together with the narcotic dependant offspring.
2. Both parents literate.
3. First contact of the family with psychiatric services.

Exclusion Criteria
1. Marriage of the narcotic dependant offspring.
2. Multiple drug dependence in the offspring.
3. Psychosis in any family member.

Controls, defined as couples with no obvious psychopathology in their offspring, were obtained through random personal contacts, and were matched with the experimental group on the parameters of age, years of education, socio-economic status, duration of marriage and size of family.

After obtaining informed consent for participation in the study, the 12 item Goldberg General Health Questionnaire (GHQ; Goldberg, 1972) and the Subjective Well Being Inventory (SWBI; Nagpal and Sell, 1985; Sell and Nagpal, 1986; Appendix 1) were administered to the subjects.

Results

Over a period of 7 months, of 54 potential cases screened, 21 fulfilled the study criteria. The sample characteristics of narcotic parents and controls are presented in Table 1; as apparent, the two groups are comparable on all the variables studied.

Table 1. Sample characteristics of narcotic parents and controls

|                      | Narcotic parents (n=21) | Controls (n=21) |
|----------------------|-------------------------|----------------|
| Age of fathers (years)* | 52-68 (57±3.8)          | 51-65 (58±3.3) |
| Age of mothers (years)* | 45–50 (52±4)           | 45–60 (52±3.9) |
| Father's education*    | 14–18 (16.4±1.5)        | 14–18 (16.5±1.5) |
| Mother's education*    | 13–18 (15±1.6)          | 13–18 (14.8±2.7) |
| Income <Rs. 1500 p.m.  | 3                       | 4              |
| >Rs. 1500 p.m.         | 18                      | 17             |
| Years of marriage**    | 28–35 (30.7±2.4)        | 25–40 (29.3±7) |
| Number of children***  | 3–11 (4.6±1.8)          | 2–7 (4.3±1.2)  |

* N. S. (Student's test)
** N. S. (X²—median test)
*** N. S. (Fisher's exact prob. test)

The GHQ and the SWBI results are presented in Tables 2 and 3. As apparent:

Table 2. GHQ profiles in narcotic parents and controls

|                      | GHQ 'case' | GHQ 'non-case' |
|----------------------|------------|----------------|
| A. Narcotic fathers (n=21) | 7          | 14            |
| B. Narcotic mothers (n=21) | 15         | 6             |
| C. Control fathers (n=21)  | 0          | 21            |
| D. Control mothers (n=21)  | 4          | 17            |

A vs. C: p<0.0043 (Fisher's exact prob. test)
B vs. D: p<0.01 (X² test)
A vs. B: p<0.05 (X² test)
C vs. D: N. S. (Fisher's exact prob. test)
Table 3. *SWBI profile* in narcotic parents and controls.

| SWBI subscale                        | Narcotic parents (n=21) | Control parents (n=21) | Significances between |
|--------------------------------------|-------------------------|------------------------|-----------------------|
|                                      | A Fathers               | B Mothers              | C Fathers             | D Mothers             | AVs. C | BVs. D | A Vs. B | C Vs. D |
| Subjective well-being-positive affective@ | 10.3±2.7                | 10.6±1.18              | 7.1±2.2               | 7.8±2.3               | <.001* | <.001* | N.S.*   | N.S.*   |
| Expectation-achievement congruence@  | 9.1±2.4                 | 9.7±1.8                | 6.7±1.8               | 7.4±2.2               | <.01*  | <.01*  | N.S.*   | N.S.*   |
| Confidence in coping@                | 9.8±1.9                 | 9.8±1.9                | 5.9±1.2               | 6.2±1.5               | <.01** | <.01** | N.S.*   | N.S.*   |
| Transcendence@                       | 11.4±2.6                | 10.8±1.6               | 7.8±2.1               | 7.7±1.9               | <.02*  | <.02*  | N.S.**  | N.S.*   |
| Family group support@                | 9.1±2.4                 | 10.1±2.5               | 5.6±1.2               | 5.4±0.9               | N.S.** | N.S.***| N.S.*   | N.S.*   |
| Social support@                      | 11.2±2.6                | 11.3±2.2               | 8.2±2.6               | 7.0±2.7               | <.01*  | <.01*  | N.S.*   | N.S.*   |
| Primary group concern@               | 10.6±1.3                | 10.8±1.3               | 10.1±2.8              | 10.9±1.9              | N.S.** | N.S.** | N.S.*   | N.S.*   |
| Inadequate mental mastery@@          | 14.8±3.9                | 13.9±3.5               | 16.0±3.6              | 16.8±2.6              | N.S.*  | <.01*  | N.S.*   | N.S.*   |
| Perceived illhealth@@                | 15.2±3.8                | 11.7±4.3               | 16.0±2.4              | 14.9±2.5              | N.S.** | N.S.** | <.01*   | N.S.*   |
| Deficiency in social contact@@       | 8.7±2.7                 | 8.5±1.5                | 10.7±1.6              | 10.5±2.9              | <.02** | <.01*  | N.S.*** | N.S.*   |
| General well-being negative affect@  | 11.0±3.2                | 11.4±1.8               | 14.8±0.5              | 14.9±0.3              | <.01** | <.01** | N.S.**  | N.S.*** |

@Lower score indicates better well-being, @@Higher score indicates better well-being
*Student's t test, **X* (median) test, ***Fisher's exact prob. (median) test
rent, narcotic parents were more psychologically dysfunctional than controls, and narcotic mothers were worse affected than their husbands.

Discussion

This study evaluated both ends of the spectrum of psychological health: psychological morbidity and subjective well-being. From Table 2 it is clear that there were significantly more psychiatric 'cases' (as defined on GHQ screening) in narcotic parents as compared with controls; furthermore, amongst narcotic parents, mothers were more likely to be 'cases' than fathers. An informal diagnostic interview conducted on subjects identified as 'cases' indicated 4th digit diagnoses falling under the general rubric of Adjustment Reaction (ICD9, 309).

From Table 3 it is observed that narcotic parents experienced less well-being, fulfillment of aspiration, confidence in coping, spiritual satisfaction, social support, and social contact as compared with controls. Narcotic mothers additionally experienced a lesser ability than controls to cope with life phenomena that potentially disrupted mental equilibrium, and had a higher perception of personal ill-health than had their husbands. Interestingly, narcotic parents and controls did not differ on measures of satisfaction with family relationships, family support and cohesiveness, and perception of physical ill-health.

From this evaluation of a variety of facets of psychological well-being and morbidity, the following inferences seem warranted: narcotic parents experience greater (clinically significant) psychological distress than do controls, and impairment is more in narcotic mothers as compared with their husbands.

That psychological dysfunction exists in parents of drug abusers has long been recognised. For example, Hawks et al. (1969) found 5% of fathers and 14% of mothers of methylamphetamine abusers to have a non-substance abuse-related psychiatric disorder. Rosenberg (1971) noted that over 1/3 of the parents and older siblings of a group of adolescent drug addicts required psychiatric treatment (behaviour disorders prevailing in the males, and neurotic/depressive disorders in the females). Haastrom and Thomsen (1972) observed that 13% of drug addicts' fathers and 25% of the mothers had a history of psychiatric admission.

Such findings notwithstanding, hitherto emphasis has lain on the identification of parental personality psychopathology (which putatively accounts for the off-spring's deviance) rather than on the identification of parental psychological distress (Sarmah et al., 1988). For example, recent reviews (Jaffe, 1985; Hawkins et al., 1985; Gordon, 1985) have suggested family characteristics associated with substance abuse, but have failed to describe parental psychological dysfunction other than aspects of personality and substance abuse behaviour; perhaps the nearest attempts to identify parental psychological distress are studies of family burden associated with drug abuse.

It may be argued that the psychological dysfunction in the parents prompted an unhappy family atmosphere which in turn predisposed to the off-spring's drug abuse. However, in view of the nature of psychological dysfunction observed in this study at least, a more likely explanation is that the dysfunction obtained reflects psychological distress, resulting from the stress of having to cope with the burden imposed upon the family by the narcotic dependant offspring. In support of this inference are our findings that narcotic parents perceive their family
relationships, support and cohesiveness to be satisfactory. The greater impairment observed in mothers suggests that narcotic mothers, perhaps by virtue of spending more time and emotional energy in the home, bear a larger share of the family burden then do their husbands. We hasten to add, however, that the applicability of our findings may be restricted to Indian families as considerable cross-cultural differences in family norms exist.

We conclude that when treating narcotic dependant patients, it behoves the psychiatrist to screen the parents for potential psychiatric ill-health; parents may need psychiatric intervention on merit of individual psychiatric problems if not as a part of the general plan of psycho-social management of narcotic dependance. Attention should be especially directed towards the mother, who appear to be more vulnerable. The areas of strength and dysfunction tapped by the S W B I may indicate avenues for potential psychotherapeutic forays e.g., with regard to improving parental coping skills, increasing their social network, promoting better utilization of intra-and extra-family social supports systems, and providing general supportive psychotherapy. An attitude that the parental psychological problems will remit once the offspring is rid of the drug habit is foredoomed to fail as narcotic dependance is associated with a protracted course, frequent relapses and a poor overall prognosis. We hope that this report will sensitize clinicians to the psychological needs of narcotic parents.

REFERENCES

Channabasavanna, S. M. and Andrade, C. (1987). Family therapy: An overview. Scientific Chapter of the proceedings of the 7th Annual Conference of the Indian Psychiatric Society (A. P. Chapter), 4-10.

Goldberg, D. P. (1972). The detection of psychiatric illness by questionnaire. Maudsley Monographs No. 21, Appendix 6:139-146. London : Oxford University Press.

Gordon, A. M. (1985). Psychosocial aspects of drug abuse. In: Granville-Grossman, K. (Ed.). Recent Advances in Clinical Psychiatry, No. 5. Edinburgh : Churchill Livingstone, 49-61.

Hawkins, J. D., Lishner, D. and Catalano, (Jr.), R. F. (1985). Childhood predictors and the prevention of adolescent substance abuse. NIDA Research Monograph No. 56, 75-126.

Hawkins, O., Mitchelson, M., Ogborne, A. and Edwards, G. (1969). Abuse of methylamphetamine. British Medical Journal, 2, 715-721.

Jaffe, J. H. (1985). Opioid dependance. In : Kalpan, H. I. and Sadock, B. J. (Eds.), Comprehensive Textbook of Psychiatry, 4th Ed., Baltimore/London : Williams and Wilkins, 987-1003.

Nagpal, R. and Sell, H. (1985). Subjective Well-Being. SEARO Regional Health Papers No. 7, New Delhi : WHO.

Rosenberg, C. M. (1971). The Young addict and his family. British Journal of Psychiatry, 115, 907-908.

Sell, H. and Nagpal, R. (1986). Brief on the Subjective Well-Being Inventory (S W B I), unpublished manuscript, personal communication.

Wermuth, L. and Scheidt, S. (1986). Enlisting family support in drug treatment, Family Process, 25, 23-33.
Appendix 1: Dimensions of well-being assessed by the Subjective Well-Being Inventory (SWBI; Sell and Nagpal, 1986).

1. Subjective well-being, positive affect: feelings of well-being arising out of an overall perception of life as functioning smoothly and joyfully.

2. Expectation-achievement congruence: feelings of well-being generated by achieving what one aspires to or expects.

3. Confidence in coping: subjective perception of one's coping potential.

4. Transcendence: Feelings of subjective well-being derived from spiritual life and the sharing of values.

5. Family group support: positive feelings derived from the perception of the larger family as supportive, cohesive and emotionally attached.

6. Social support: perception of the social environment as supportive in general and in times of crisis.

7. Primary group concern: Happiness or worry about the relationship with spouse and children.

8. Inadequate mental mastery: reduced well-being from a sense of insufficient control or inability to deal efficiently with life phenomena that are capable of disturbing the mental equilibrium.

9. Perceived ill-health: worry over or suffering from physical complaints.

10. Deficiency in social contacts: worries over missing a friend, or being disliked, or over an inadequate social network.

11. General well-being, negative affect: negative feelings about, and outlook upon, life as a whole.