

The Effect of Psycho- Educational Intervention on Knowledge, Coping and Burden among Caregivers of Person Substance Use Disorders

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Abstract

Substance use disorder is a multidimensional problem which threatens the quality of life not only substance abusers but also the family members who live with them. Most of the time a member of the family assumes the role of caregiver and he or she is most burdened from this process. Considering that it is necessary to appropriately provide the training to caregivers and evaluate their needs for caregiving.

Aim of the study: The aim of the present study was to evaluate the effect of a psych educational intervention on knowledge, coping and burden among caregivers of persons with substance use disorders .

Subjects and Method: Study design: The study was followed a quasi-experimental design.

Setting: The study was conducted at the addiction outpatient's clinic in Tanta Mental Health Hospital; the hospital is operated by the Ministry of Health and Population.

Subjects: The subjects of this study were 40 caregivers of persons with substance use disorders chosen by a convenience sample.

Tools of data collection: Three tools were used for this study:

Tool I : Structured substance use disorders knowledge questionnaire,

Tool II :-Family crisis oriented personal evaluation scale (F.COPES) and

Tool III :- The Zarit Burden caregiver scale

Results: there was an improvement of the mean of the total score of caregiver's' knowledge and Family crisis oriented personal evaluation scale (F.COPES) and there was a reduction of the mean of the total score of Zarit Burden Caregiver.

Conclusion:-It can be concluded that psycho-educational intervention was effective in improving knowledge, coping and reducing caregivers' burden.

Recommendations: Based on the results of this study it is recommend that identifying educational needs and implementing supportive and coping interventions for caregivers should be an integral part in recovery process

Key words Substance Use Disorders, Caregivers, Coping, Burden

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I. Introduction

Substance use disorders have devastating physical, mental, and socio-economic repercussions not only for patients but also for their families. Substance use disorders are characterized by an array of mental, physical, and behavioral symptoms that may cause problems related to loss of control, strain to one's interpersonal life, hazardous use, tolerance, and withdrawal.⁽¹⁻³⁾

Substance use disorder is a critical public health concern for which the global burden far exceeds the difficulties experienced by many of the 250 million drug users or the two billion alcoholic drinkers worldwide.⁽⁴⁾ It is estimated that a total of 246 million people, or 1 out of 20 people between the age group of 15 and 64 years, used an illicit drug in 2013 (World Drug Report 2015). , thus, with the increasing numbers of substance uses, the problems and challenges faced by the caregivers of these groups of patients are widening and emerged.⁽⁶⁾

Psychiatric researches on caregiving have increasingly recognized the price paid by families of persons with mental health problems and their contributions to the care process. However, the studies have traditionally been restricted to caregivers of persons with mental disorders like schizophrenia or bipolar disease and investigations on substance use disorders have been slowly following the path^(1,4). The delay is probably due to a difficult progression from focusing on the role of the family in generating or exacerbating the drug user's problems, through identifying family members as recipients of care. Still today, primary challenges remain the

broadening of the substance abuse treatment attention from the individual to the family and its active participation in the recovery process' ⁽³⁾

In the presence of dependence, the whole family structure can be shaken, however the family members suffer varying degrees of closeness and distancing, faced with the negative impacts of this behavior. Substance abuse disorders adversely affect the individual as well as those around in terms of physical, emotional, and financial distress resulting in problems, difficulties or adverse events which impact the lives of the significant others. This adverse impact has been defined as burden. Burden is referred to as the costs incurred by the caregivers in terms of economic, social and psychological strains. ^(7, 8) Commonly in the family, a member assumes the role of caregiver being the person most directly linked to the care and/or emotionally to the person dependent on the drug, a condition that not only directly affects caregiver's quality of life but also predisposes to deteriorated psychological functioning and the emergence of psychiatric problems ^(6, 9). In this respect researches into the impact of caregiving shows that one third to one half of caregivers suffers significant psychological problems and experience higher rates of mental health problems than the general population. ^(5, 10)

Caregivers of substance dependent persons have increased prevalence of illness and domestic violence and interpersonal dysfunction in terms of problems with social adjustment, the relationship with the drug using person, family cohesion, interpersonal conflict and stress. ^(5, 8) Moreover caregivers must deal with legal and financial problems and involvement with the police in those homes. The combination of problems can have a substantial and widespread impact ⁽¹¹⁾ For example, the families of substance –dependent persons have health care utilization rates that potentially can be four times greater than that of average families in the general population. ^(3, 5)

Caregivers have a key role in supporting a relative with substance use disorders by assuming multiple roles in caring process, including taking day-to-day care, supervising medications, taking the patient to the hospital and having to deal with the behavioral disturbances of the patient. The caregiving role frequently has detrimental effects on caregiver's general wellbeing, the extent of which is dependent predominantly on their coping strategies' ^(3, 12).

Coping can be defined as cognitive and behavioral efforts to manage demands perceived as taxing the resources of an individual. Authors have distinguished mainly between emotion-focused and problem-focused coping, or between active or approach and passive or avoidance coping. ⁽¹³⁾ Active coping includes attempts to reappraise, modify, and solve problems, while avoidance or passive coping is related to attempts to avoid problems and engage in indirect attempts to reduce distress.

The caregivers develop various kinds of coping strategies to deal with the burden of caregiving role . Without proper coping mechanisms, the stress of caring for a loved one who is struggling with substance use disorders can result in chronic medical and psychological health problems and overall reduction in quality of life. ^(6, 14) Despite this, limited research has been undertaken about affected family member coping and few resources are available to assist affected family members to cope . Despite a wide acknowledgement that caregivers are seriously affected by the drug abuse, and general acknowledgement that they are not only concerned about their loved one but also deal with the negative effects of the disease, they have had limited options for help or treatment involvement. This is unfortunate, because research suggests that caregivers can not only benefit from receiving help, but they can also influence the cared substance dependent persons ^(5, 15).

Significance of the problem

Currently, international and national policies aimed at drug dependence advocate community care for the user, making the family an important ally in the recovery process. However ,despite the need for participation and responsibility of the family members in the therapeutic process , substance dependence is considered as a 'family disease', the services often focus on the care of the users ,relegating the caregivers to a secondary degree ,not valorizing their need for care and support ⁽¹⁶⁾). Thus, the mental health nurses need to take timely care of the needs of the caregivers and provide necessary support and interventions. This would help the caregivers to deal effectively with the burden of caregiving using healthy coping strategies and in turn improving their caregiving role.

Therefore this study was carried out to provide caregivers of person with substance –dependence with information and skills aiming at minimizing their burden and enhance their coping.

Aim of the study:

The aim of the present study was to evaluate the effect of psych educational intervention on knowledge, coping and burden among caregivers of person with substance use disorders

Research hypothesis –

Caregiver's knowledge and coping are expected to be improved after implementation of psycho educational intervention and at the same time caregiver's burden is expected to reduce after implementation of psycho educational intervention

Subjects and Method

Study design:

The study followed a quasi –experimental design.

Setting:

The study was carried out at addiction outpatient's clinic in Tanta Mental Health Hospital. The hospital is operated by the Ministry of Health and Population. The working days at the clinic are three days per week. Health services provided by the clinic are screening the new cases, providing medication, and the follow-up cases.

Subjects:

The subjects of this study were composed of 40 caregivers of substance dependent person who chosen by a convenience sample. The sample size was calculated using Epi-Info software statistical package created by World Health Organization and center for Disease Control and Prevention, Atlanta, Georgia, USA version 2002. The criteria used for sample size calculation were as follows: 95% confidence limit, expected percentage of patients with good knowledge, coping and burden of > 60% of total score is 40%. The subjects meet the following criteria:

Inclusion criteria:-

- The person who provide direct care and live with substance dependence person at home regardless of the type of drug use.
- Age more than 20 and less than 55 years.
- Agree to participate in the study.

Exclusion criteria:

- Having psychiatric disease or presence of severe neurologic disorders and chronic systemic diseases.
- Caregivers who was use of any type of illicit drugs.
- Having another family member with mental illness (e.g., schizophrenia, mood disorder and opioid dependence) or chronic medical illness in the same household

Tools of data collection:

Data of study was carried by using three tools.

Tool I: Structured substance use disorders knowledge questionnaire,:

This tool was developed by the researchers after a thorough of related literatures . It aims to assess caregivers' knowledge regarding substance abuse disorder. It consists of 24 items, which in turn classified into 6 parts (definition - causes –symptoms – types of the substance dependent – stages of substance dependence and treatment of substance dependence) and each part contained 4 items.

The answer for each item was: correct and complete answers will be scored 2, correct and incomplete answers will be scored 1 and incorrect answer will be scored 0.

Scoring system

A total composite score was calculated by adding together the scores for each item, total scores is ranged from 0 to 48, with higher scores was indicating good knowledge. The total score of knowledge was categorized as follows:-

- Poor knowledge: < 50 % of the total score.
- Fair knowledge: 50 % - < 70 % of the total score.
- Good knowledge: ≥ 70% of the total score.

II- Tool two: Family Crisis Oriented Personal Evaluation Scale (F.COPES)

The F-COPES is a 30-item, tool, developed by McCubb(1987)⁽¹⁷⁾ It is a self-report questionnaire used to measure family coping with stress. The F-COPES helped to identify coping levels of families, which can reflect the ability of the family to adapt to stressful situations. The measure uses a 5-point Likert Scale with responses ranging from 1 (strongly disagree), (2) (moderately disagree), (3) (neither agree nor disagree), (4) (moderately agree), (5) (strongly agree). It contained five subscales:

1- The acquiring social support subscale is a nine-item subscale that measures a family's ability to acquire support from friends, relatives, neighbors, and extended family.

2- The reframing subscale is an eight-item subscale that assesses the family's ability to redefine stressful events to help them be manageable by the family.

3 -The seeking spiritual support subscale is a four-item subscale that examines the family's ability to acquire spiritual support.

4 -The mobilizing family to acquire and accept help subscale is a four-item subscale that measures the family's ability to seek community resources and accept help from others.

5-The passive appraisal subscale is a four-item subscale that assesses the family's ability to accept difficult issues minimizing reactivity.

The F-COPES subscales are calculated and then totaled together. The higher the scores, the better the problem-solving and behavioral responses found during difficult situations.

Scoring system:

<60% low adaptive coping

60-75 moderate adaptive coping

>75 high adaptive coping

Tool III: - The Zarit Burden caregiver scale

The Zarit Burden Interview (ZBI) was developed by Zarit et al (1980) ^(18.) to measure subjective burden among caregivers. Items were generated based on clinical experience with caregivers and prior studies resulting in a 22-item self-report inventory that examines burden associated with functional/behavioral impairments and the home care situation. The items are worded subjectively, focusing on the affective response of the caregiver.

Scoring system

- Each question is scored on a 5 point Likert scale ranging from (0) never to (4) nearly always present. Possible responses :0,never; 1,rarely; 2 , sometimes; 3 ,quite frequently ; and 4, nearly always. Total scores range from 0 (low burden) to 88 (high burden). Score values and interpretation are guidelines only.

-No or minimal burden 0 to 20.

-Mild to moderate burden 21 to 40

-Moderate to severe burden 41 to 60

-Sever burden 61 to 88.

The tools of the study are supported by covered sheet about socio-demographic characteristics of the studied caregivers. It aimed to elicit data about age ,sex ,marital status , educational status ,residence and income .

Method

- **An official permission** to carry out the study was obtained from the director of addiction outpatient's clinic of Tanta Mental Health Hospital.

-Ethical considerations:

-An oral consent was obtained from the study subjects after appropriate explanation of the nature and purpose of the study.

- Anonymity and confidentiality of the collected data and the right to withdraw from the study at any time was assured.

- Nature of the study will not cause harm and/or pain to the entire sample.

- **Developing tools:** - Tool 1 was developed by the researchers after a thorough review of related literatures. Tool 2 and3 was translated by the researchers into Arabic language. Tools of the study were tested for their translation and content validity by a group of five experts in psychiatric medicine and psychiatric nursing. Then a test - retest reliability was applied on study tools (alpha reliability 0.89, 0.85 and 0.92) respectively.

-**A pilot study** was carried on 10 % of the sample study to ascertain the clarity and applicability of the study tools. In addition it serves to estimate the approximate time required for collecting the data, as well as to identify any obstacles that might be faced during data collection and these caregivers were excluded later from the study. According to pilot study there was no modifications don on tools of the study.

-The actual study:

The actual study was divided into three phases:-

Phase 1: Assessment phase :-(Pretest)

The studied subjects were interviewed by the researchers using the tools of the study. The interview was conducted on an individual basis .The interviewing ranged from20-30 minutes.

Phase 2 :(Development of psych educational intervention Phase)

- The researchers developed the psycho educational intervention based on a review of the related literatures. The overall objective is to provide the studied subjects with knowledge about substance use disorders and to develop their skills of coping, to help them reduce their burden and improve their ways of coping.

- The Psycho educational intervention was composed of educational sessions, together with psychosocial training. The educational sessions cover a number of different areas of knowledge, including information about substance dependence (definitions, causes, risk factors, types, treatments). While the psychosocial training

sessions emphasized on the coping strategies and skills training for handling the behavioral problems of the patient, advice about the emotional repercussions of being a caregiver and advice about self-care.

Phase3 :(Intervention Implementation Phase)

- The Psycho educational intervention was implemented on small group basis. Each group composed of 8-10 subjects. Each group attended a total 9 sessions. Each session was ranged from 45 to 60 minutes and subjects attend 2 sessions per week for 4weeks.

-It was implemented through 6 months from February to August 2018.

-- The Psycho educational intervention was implemented by using lectures, group discussion, questions answering and skill training. Teaching materials were included power point presentation, videos, posters, and role play. Handout was distributed to the subjects at the end of the psycho educational intervention. It was written in a simple Arabic language and supplemented by photos and illustrations to help the study subjects to understand the content easily.

-The content of the psycho educational intervention was implemented 9 sessions as follows:

- **Session one** was an introductory session that emphasized acquaintance between the group members as well as the researchers and explanation of the purpose, schedule and outline of the program content.
- **Session 2-4** emphasized on the knowledge about substance abuse disorder (definition- causes- type-stage and treatment).
- **The core sessions (5-6)** were to help subjects to cope with the stress and burden of caregiver role. The researchers taught the subjects some of the stress management techniques such as time management, problem solving skills and decision-making guidance. Additionally, the researcher stressed on the routine exercise and informed subjects that at least three times a week will help the body to reduce tension such as walking. Importance of a healthy diet that rich in vitamins, avoid smoking, coffee intake and excessive drinking tea. The researchers guides the caregivers' subjects to keep the lines of communication open with family and friends and seeking social support as a method of coping and buffer factor of the stress of caregiver role.
- **Session 7-8:-** The aim of these sessions was to enable the study subjects to deal with behavioral and emotional change of the patient such as anger and manipulative behavior.
- **Finally at session 9:** the revision of the program and clarification of any program content was done and posttest was conducted.

Phase4 : (Evaluation Phase) Post test 1- post test2:

The evaluation of the implemented the psycho educational intervention was done through reapplying of tools of the study twice:

- Immediately after implementation of the program at session 8 (posttest 1).
- Three months later after the program implementation (posttest 2).

-Statistical analysis

Using SPSS (version 20) for coding, entering and analyzing data. The range, mean, and standard deviation were calculated for quantitative data. Comparison was done using chi-square for qualitative data. For comparison between means of two parametric variables student t-test was used. Spearman's correlation coefficient was used for evaluation between variables of the study. Significance was adopted at P value < 0.05 for interpretation of results of significance. High significance was adopted at P value < 0.01.

II. Results

Table (1) Distribution of the Studied Caregivers According to Their Socio-demographic Characteristics

Socio-demographic characteristics	N=40	%
Sex		
Female	24	60.00
Male	16	40.00
Age in years		
20-	9	22.50
30-	10	25.00
40-	13	32.50
50 or more	8	20.00
Marital Status		
Single	4	10.00

Married	25	62.50
Widowed	11	27.50
Education Status		
Illiterate	10	25.00
Read and Write	9	22.50
Secondary School	14	35.00
University degree	7	17.50
Occupation		
House wife	5	12.50
Having work	8	20.00
Not having work	27	67.50
Residence		
Rural	16	40.00
Urban	24	60.00
Kin Relationship to Patient		
Mother	14	35.00
Father	8	20.00
Wife	6	15.00
Sister	7	17.50
Brother	5	12.50
Income		
Enough	15	37.50
Not enough	25	62.50

Table (1) shows, the distribution of the studied caregivers according to their socio-demographic characteristics. It is noticed that 60% of the subjects are female .In relation to age, about third of the studied subjects were 40years old .Concerning marital status the majority of the subjects were married (62.5%). In relation to educational level, 35% of the participants had secondary school while others had university degree 17.5 % and illiterates represent 25% of the sample. Regarding their state of work, about two thirds of the participants were not working (67.5%) and 60% of the participants were living in urban areas. Regarding the kin relationship to the patient, the majority of participants were mothers 35% .Concerning income 62% of the participants had not enough income.

Table (2):- Distribution of the Studied Caregivers regarding their total Mean scores of Burden and the Extent of Change among the Three Phases of The Psycho educational Intervention

Phases of the program	Burden			Comparison	Difference		Paired T-test	
	Mean	±	SD		Mean	SD	t	P-value
Pre	58.771	±	25.833	Pre - Immediate	31.000	25.248	7.264	0.000
Immediate (Post 1)	27.771	±	7.893	Immediate - Three months later	43.200	26.017	9.823	0.000
Three months later (Post 2)	15.571	±	4.272	Post - Three months later	12.200	8.481	8.510	0.000

Table 2 presents the distribution of the studied subjects regarding their total mean scores of burden among the three phases the psycho educational intervention. The table revealed that there are significant reduction in the mean score of the caregivers' burden pre-immediate and three months later of intervention implementation (58.771 ±25.833), (27.771±7.893), (15.571±4.272) respectively. It was also noticed that burden of the caregiver's decline to (31.0± 25.248) from Pre to Immediate implementation and (12.200±8.481) from Post implantations to three months later.

Table (3):- Distribution of the Studied Caregivers regarding their Total Means Score of Knowledge and The extent of Change among the three Phases of The Psycho Educational Intervention

Phases	Knowledge			Comparison	Difference		Paired T-test	
	Mean	±	SD		Mean	SD	t	P-value
Pre	11.771	±	5.202	Pre - Immediate	-6.257	5.490	-6.743	0.000
Immediate (Post 1)	18.029	±	3.792	Pre - Three months later	-3.286	7.936	-2.450	0.020
After Three months (Post 2)	15.057	±	4.627	Immediate - Three months later	2.971	6.510	2.700	0.011

Table 3 presents the distribution of the studied subjects regarding their total mean scores of knowledge among the three phases of the psycho educational intervention. The table revealed that caregivers' knowledge improved immediately and three months after intervention implementation although; the improvement of knowledge after three months is less than the one which happened immediately but is still more than before the implementation .Mean scores pre, immediately post and three months after the psycho educational intervention were as follows; (11.771±5.202), (18.029 ± 3.792), (15.057±4.627) respectively.

Table (4):- Distribution of The Studied Caregivers regarding their Total Mean Scores of Coping and the extent of Change among the Three Phases of The Psycho Educational Intervention

Phases	Coping			Comparison	Difference		Paired T-test	
	Mean	±	SD		Mean	SD	t	P-value
Pre	65.686	±	8.213	Pre - Immediate	-48.629	13.578	-21.188	0.000
Immediate (Post 1)	114.314	±	11.575	Pre - Three months later	-32.943	16.126	-12.085	0.000
Three months later(Post 2)	98.629	±	13.242	Immediate - Three months later	15.686	17.613	5.269	0.000

Table 4 presents the distribution of the studied subjects regarding their total mean scores of coping among the three phases of the program .The table revealed that there are significant improvements in the mean score of the caregivers' coping pre, immediate and three months after the psycho educational intervention implementation (65.686 ± 8.213), (114.314 ± 11.575), (98.629 ± 13.242) respectively. Although the improvement of coping in three months is less than immediate but is still more than before implementation of the psycho educational intervention.

Table (5). The correlation between Knowledge, Burden and Coping among Studied Caregivers

Correlation	Knowledge		Burden	
	r	P-value	r	P-value
Burden	-0.785	<0.001*		
Caregiver coping	0.882	<0.001*	-0.767	<0.001*

Table (5) illustrate the correlation between knowledge, burden and coping among the studied subjects, the results revealed that, there was a negative correlation between burden and knowledge (when the subjects were more knowledgeable , the burden of care givers decreased) . It was observed that there was a positive correlation between knowledge and coping whereas the subject is knowledgeable, the more he is likely to cope better with caregiving role. At the same time the table shows that there was negative correlation between burden and coping.

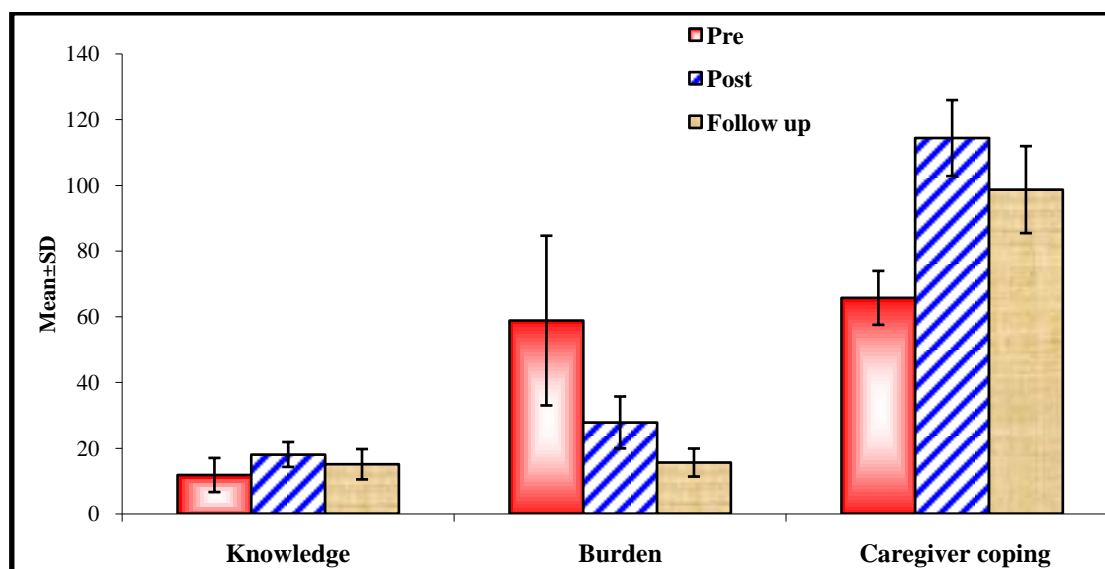


Figure (1) The Effect of psycho-educational program on the knowledge, burden and coping of the caregivers pre-post and after follow up implementation of The Psycho Educational Intervention

The figure shows the effect of the psycho educational intervention on the knowledge, burden and caregivers coping pre-post and after follow up implementation of intervention., it was noticed that there is an improvement in the knowledge and caregiver coping also, burden was decreased after program implementation among the studied subjects but this result slightly decline after three months of the program .

III. Discussion

Substance dependence is a multidimensional problem, which threatens the quality of life of not only substance abusers but also the family members who live with them. Most of the time a member of the family assumes the role of caregiver and he or she is most burdened from this process. Considering that it is necessary to appropriately provide the training to caregivers and evaluate their needs for caregiving.

The present study revealed that most of the caregivers were females and the majority of participants kin relationship to the patient, were mothers, this finding can be explained by the fact that in Egyptian's culture, either mothers or wives are responsible on caring her family. For more explanation, patients with substance use disorders usually start in adolescence at a younger age, and thus, the original family (mothers) cares for their children. Others start in adulthood during marriage, and then the wife is responsible of the care of her husband. This result was similar to those of the study done by **Marcon et al (2012)** about quality of life and depressive symptoms among caregivers and drug dependent people, found that 90.8 % of the caregivers were females ⁽⁹⁾ Another study done by **Mattoo et al , (2013)** about family burden with substance dependence at India , who found that 64.1% of caregivers were wives and mothers ⁽¹⁾.

In relation to age, about one third of the studied subjects were 40years old . This may be interpreted in the light of the previous result that referred that most of caregivers were mothers, the average age of the Egyptian mothers who have young children. This result is in agreement with a study by **Vaishnavi et al, (2018)** who reported that 90% of the caregivers in their study were females and regarding the age the mean was 41.60 ± 14.45 ⁽³⁾.

The findings of the present study revealed that about two thirds of the participants' income was not enough. It may be due to the fact that most of the studied caregivers were not working because of their caregiving role. Also, drug dependency affects productivity of and his ability to work member and the cost of financial resources during long treatment. These results were similar to those of the study done by **Kaur & Ajinkya (2017)** who showed that majority (68%) of the patients was from lower socioeconomic class ⁽¹⁰⁾.

Results of the current study are proved that studied caregivers' burden was reduced and their knowledge and coping was improved after implementation of the psycho-educational intervention. Along with

these results, previous studies showed that caregivers, who receive education and training about addiction problems and who receive support to develop coping skills, can help to ensure improved outcomes^(19,20).

Regarding caregivers' burden, the results of the present study reported that the psycho educational intervention has a positive effect on family caregivers' burden which the burden of the caregivers was significantly reduced after implementation of the psycho educational intervention. Similarity other studies mentioned participation of caregivers of patients with addiction problems in an educational and supportive group, results in reducing caregiver's burden and enhanced adaptability of their caring role^(21,22). In the same stream, a study conducted by **Latino (2012)** which compared different models of family interventions, the researchers concluded that psycho- education was the most useful intervention in decreasing caregivers' burden⁽²³⁾.

This result may be attributed to the fact that many caregivers suffered and complained from inadequate knowledge and skills, being unfamiliar with the type of care they must provide or the amount of care needed and often feel unprepared to provide care, assume caregiving role, and receive little guidance from the health care providers. So they have a desire to understand knowledge as factual data about what substance abuse is; warning signs of substance abuse; treatment, how to deal with behaviors and emotional changes of the patients. In the present study, studied caregivers were provided with needed knowledge regarding substance use disorders. As a result, caregivers felt some control and autonomy over their caregiving role resulting in reduction of their burden.

Another rational for reduction of caregiver's burden is that the psycho- educational intervention was implemented in a small group and group discussion was used as a method of teaching. During implementation of the intervention, researchers were very keen to provide warm, friendly and respectful interaction between researchers and studied caregivers and between caregivers themselves. This type of interaction gives subjects opportunities for mutual exchange and sharing their experience and express their negative feelings openly. Additionally this interaction may give rise to emotional support and practical help which is tended to the post intervention. In this respect **Sharma et al (2017)** mentioned that once caregivers feel sheltered, they talk openly about their experience and show gratefulness and feeling of relief and additionally they stated group discussion is practically beneficial because through sharing, the participants realize that the trauma, shame and stigma they may suffered is universal and stop taking the process very personally⁽²²⁾.

Without proper coping mechanism the stress of caring for a loved one who is struggling with substance abuse disorders can result in chronic medical and psychological health problems. The results of the present study denoted that the caregivers' coping was significantly improved after implementation of the program. This may be due to the effect of the skills training of program, which included stress management techniques such as time management, problem solving skills, decision-making guidance and meditation, to help caregivers cope with their stress, enhancing emotional and coping skills to deal with the caregiver's anger and frustration.

Additionally, using role play as a method of teaching in implementation the psycho-educational intervention was very useful for helping the caregiver better understand how to communicate with the care patients and manage patient's behaviors. As a result of this subjects' awareness of strategies and ways of coping with caregiving stress is increased. In this respect, other studies stated that psycho-educational programs helped caregivers to become more competent and confident^(24,25). These results were also in accordance with a study by **Fooladia .et.al (2014) & Rani .et.al (2016)** about drug and alcohol education for consumer workers and caregivers who found that most of participants reported that the program is very interesting and it was useful to them in improving their coping as formal or informal caregivers and the program influenced the way they thought about people using substances^(26,27).

IV. Conclusion

It can be concluded that the psycho-educational intervention about substance use disorders had a positive effect on improving the caregivers' level of knowledge and coping as well as reducing the caregivers' burden. It helped them acquiring coping skills to improve their caregiving role

V. Recommendations

- Awareness and educational programs for nursing staff of psychiatric hospital about importance of supporting family care giver of patients with substance use disorders.
- Educational programs about knowledge and how to deal with patients with substance use disorders should be included in the rehabilitation phase of hospitalized patients for their caregivers.
- Adequate researches to identify the needs of family care giver of those patients and develop different coping strategies and implementation to reduce their burden.
- Home visits should be conducted to support care givers in caring for their patients.
- Family caregivers should be an integral part in recovery process of substance use disorders

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