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# A Study to Explore the Coping Strategies and Skills Adopted By Families of Addicted Patients with View to Develop a Patient Centered Family Intervention Programme

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**ABSTRACT**
*Coping mechanisms are the unique behavioral and psychological techniques used by individuals to control, tolerate, lessen, or limit stressful situations. Substance abuse turns become the biggest family secret, which is frequently kept from both members of the family and from outsiders[6]. To investigate the coping mechanisms and abilities used by relatives of addicted patients and to build a patient-based family intervention programme, a descriptive method was used. The Stuart stress adaptation model served as the foundation for developing the study's conceptual framework. A schedule of interviews was created to examine different coping mechanisms and coping skills used by family of addicted patients in order to meet the study's goals. 50 family members of addict patients who meet the inclusion criteria were chosen using the purposive sample approach. Coping techniques a timetable for conducting interviews was used to gather the data, and descriptive and inferential statistics were used to evaluate the results. The family of addicted patients used a variety of coping mechanisms and techniques. Planning (healing, best handling) regarding sickness management measures was one of the participants' most often employed coping mechanisms (86 percent). Social support was the second-most-frequently used coping technique or skill (84.50%) by participants (advice, talk to others). Emotional expression was the third coping method listed by participants (83 percent) (crying, feeling). Employing the rivalry-based activities, 82.83 percent. While religious coping mechanisms like prayer and cultural therapy are utilised by caregivers at a rate of (78.33%), emotional support is employed as a coping mechanism in a rate of (77.75%) by subjects (friends, discuss with others). The majority of participants (76.83%) admitted to managing their patients by taking active coping measures (direct action, attempts). In contrast to caregivers, who reported utilising positive reinterpretation and growth as a method (different light, more optimistic) to cope with their clients, respondents (70%) accepted and accommodated (reality, learn) with their related disease as a component of coping. Subjects employ mental disengagement (mind distraction) as a coping mechanism in 64.16 percent of cases. Subjects engage in conduct that is disengaging (60%). (trying, solving problems). Subjects adopt self-constraint as a tactic in 49.25 percent of cases (take initiatives). The subjects' substance abuse rate is 45%. (alcohol, drugs). Contrarily, 42.6 percent of participants indicated using denial as one of their methods, or refusing to accept reality. Only 33.5 percent of the individuals reported adopting humour (laughter, amusement) as one of their coping mechanisms. Using a one-way ANOVA, further associations between coping mechanisms and patient demographics were found.*
***Keywords**: - coping strategies/ skills, families*

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## INTRODUCTION

Patients' age, employment, and length of treatment at the de-addiction centre were shown to be significantly correlated (P 0.05). Addiction is a condition of recurrent or ongoing intoxication caused by drug use that is harmful to the person as well as to society (natural or synthetic). Dependence and habit are both included in the definition of "addiction." [1]. A person develops addiction when they consume a psychoactive substance (such as alcohol, cocaine, or nicotine) or engage in a pleasurable activity, but their continued use of it develops into a compulsive behaviour that interferes with their ability to carry out daily tasks, such as maintaining healthy relationships at work or maintaining their physical well-being. Users might not be aware that their actions are out of control and creating issues for them and other people [2]. Addiction is a series of events that alter a person's internal makeup. As a result of these internal changes, the addict starts acting out in certain ways. Addiction becomes into a way of life as it progresses. We are more likely to develop an addictive behaviour, such as alcohol or drug dependency, when we encounter loss, sorrow, grief, despair, and other unavoidable harm or bad experiences. We look for experiences that enhance the pleasant and reduce the bad because we want to escape misery (for some people, alcohol or

drug use, may be some of these experiences) [4]. The majority of us learn to either accept these cycles or attempt to be happy all the time because we cannot completely control the cycle of serenity and agony in our life. These uncontrolled events are something the addict attempts to manage [9]. He thinks he can make the agony go away and create happy sensations whenever he wants when he consumes booze or drugs. Additionally, he has a chance to succeed initially. However, this is the point at which the procedure progresses [3]. Addiction is the unchecked pursuit of enjoyment or the avoidance of suffering. Every addict has a "connection" with a substance in order to induce a mood shift, regardless of the addiction. Acting out is the method used to achieve the mood shift (using alcohol or drugs) [8]. Addicts try to induce sensations of comfort, pleasure, or imagination through acting out. Addicts get the impression that they are in control of their mood since acting out (using alcohol or drugs) causes a shift in it [5-7]. Misuse of alcohol and other drugs is a growing societal issue that harms people on an individual, family, and community level. The expenses of substance misuse are significant for the addict, his or her family, and the community [10]. This estimate takes into account direct expenses like medical bills, settlements for accidents, and court fees. Indirect costs include lost output as a result of early mortality and disease, decreased productivity, and extra unemployment. Between 7,000 and 22,000 alcohol-related individuals get emergency room care each year. Hospital emergency rooms believe that between 10 and 30 percent of their workload is connected to alcohol [4].

**Objectives**

1. To explore various coping strategies / skills adopted by families of addicted patients.
2. To determine the relationship between coping strategies and demographic variables.
3. To develop patient based family intervention programme.

## MATERIAL AND METHODS

A study to explore the coping strategies and skills adopted by families of addicted patients and development of patient based family intervention programme. The Stuart Stress adaption model of psychiatric nursing serves as the foundation for the study's theoretical framework. It takes a wholistic approach to understanding human behaviour by including biological, psychological, and social care factors. Descriptive study was adopted as the most suitable one, as the present study tries to explore the coping strategies and skills adopted by families of psychoactive substance addicted patients. In the present study population consist of family members of addicted patients those who were visiting the De-addiction centre Kurali at the time of data collection. In this study the sample consist of 50 family members of psychoactive substance addicted patients who were visiting the Disha De-addiction centre Kurali were chosen using the purposive sampling method. To eight specialists from the department of psychiatric nursing, together with the goals, blue print, tool, and criterion grading scale, was the created tool. Karl Pearson's correlation formula was used to assess the tool's dependability, and it was found to be quite dependable. (r=0.76).The data has been collected from 50 family members of addicted patients who fulfilled the sampling criteria in March 2015 by using interview schedule which was prepared in English and Punjabi. The data collected was compiled for data analysis.

## RESULTS

Distribution of the subject shows that (10%) were in age group of 18-25, (26%) were in age group of 26-35, (22%) were in age group of 36-45, (26%) were in age group of 46-50, (16%) were in age group of above 50years.Maximum number of subjects (62%) were female, whereas (38%) of the subjects were male. Educational status wise distribution of subject's shows that 10% were studied up to 5$^{th}$standard, 2% were up to 8$^{th}$standard, 26% were up to 10$^{th}$ standard, 18% were up to 12$^{th}$ standard and 44% were graduate and above. Most of the subjects (46%) were unemployed, 18% subjects had Govt job where as equal number of subjects (18%) had private job and business. Majority (78%) of the subjects was married, 20% of the subjects were unmarried, only 2% of the subjects were widow; none of the subjects were divorced and separated. Most of the subjects (42%) were parents of the clients, 36% were brother and sister of the clients, 12% were spouse (6%) were other relatives of the clients and only (4%) were son/daughter of the clients. Most of the subjects (42%) had income above Rs. 40,000/- per month, 24% subjects having total family income between Rs.30, 000 to 39 thousands/- month whereas equal number of subjects (24%) having total family income between Rs 20,000 to 29 thousands/- month (6%) had income between Rs10 to 19 thousands /-month, only (4%) had income between Rs one thousand to 9 thousands/-month. Interpersonal relationship between most of (72%) family members were good, only 36% family members reported as interpersonal relationship were somewhat good.

overall mean percentage of the coping strategies / skills adopted by subjects was 68.84% with means 112.90±68.84. The most common coping strategies (86%) used by subjects were planning (recovery, best handle) about illness management actions with a means 13.76±2.31. Second highest strategies and skills

(84.50%) adopted by subjects was instrumental social support (advice, talk to others) with means 6.22±1.94. The third coping strategies (83%) reported by the care givers was use venting of emotion (crying, feeling) with means 9.96±2,15. Religious coping strategies (pray, culture treatment) used by (78.33%) subjects with means 9.40±2.40. Whereas 77.75% subjects take use of emotional support as coping strategies (friends, discuss with others)) with means 6.22±1.94. 76.83% subjects reported of using active coping strategies (direct action, efforts) to manage their clients with means 9.22±2.23. 70% care givers had accepted and accommodate (reality, learn) with their relative illness as a part of coping with means 8.50±1.99.Whereas 65.83% subjects reported of using positive reinterpretation and growth as a strategies (different light, more positive) to deal with their clients with means 7.90±2.16. 64.16% subjects use mind diversion (mental disengagement) as a strategies to handle situation with means 7.70±1.40. 60% subjects use behavior disengagement (trying, solving problems) withmeans (4.80±1.91). (49.25%) subjects use self-restraint as their strategies (take initiatives). (45%) subjects use substance abuse to deal with their clients (alcohol, drugs) with means 3.60±1.82. Whereas 42.6% participants reported of not accepting reality (denial) as a part of strategies. There were only 33.5% subjects reported of using humor( laugh, fun) as a part of their coping strategies. Significant relation between the age, occupation and getting treatment at de-addiction centre of clients with coping strategies /skills of subjects. Age of the clients and coping strategies and skills is significant. The calculated value of (1.99) which is greater than the tabled value of at (5%) level of significance. Hence we can conclude that age of the clients with coping strategies and skills is significantly related ($P>0.05$). Occupation of the clients and coping strategies and skills is significant. The calculated value of (3.68) which is greater than the tabled value of at (5%) level of significance. Hence we can conclude that occupation of the clients with coping strategies and skills is significantly related (P>0. Duration of getting treatment at de- addiction centre of the clients and coping strategies and skills is significant. The calculated value of (3.84) which is greater than the tabled value of at (5%) level of significance. Hence we can concluded that Duration of the getting treatment at de-addiction centre with coping strategies and skills is significantly related ($P>0.05$).Open ended questions were asked to the family members regarding various problems experienced by them related to their relatives' current condition. Problems experienced by family members were categories, frequency and percentage computed.

## DISCUSSION

The researcher interpretively discusses the study's findings in this part. The researcher completes the study by tying up all the loose ends in the debate. According to the goals of the research and literature review, the results of the current study have been addressed. Study explored various coping strategies/skills that was used by the families of patient with substance addiction , and most commonly used coping strategies were planning (recovery, best handle), instrumental social support (advice, talk to others) and use venting of emotion (crying, feeling)whereas competing activities , religious coping , emotional support , active coping , positive reinterpretation , mental and behaviour disengagement , self restrain , substance abuse were also used as coping strategy, denial and Humor were also reported a coping strategies by the care givers of patients. Use of denial and humor were reported under very rarely used coping strategies by the care givers. Open ended questions were asked from the caregivers and various problems were explored such as marital conflicts, home/family environment disturbed, job related issues, financial issues, health and wellbeing related problems and legal issues. On the basis of such problems family intervention programme developed where all these reported problems were addressed and booklet was developed and distributed to care givers. Further association between coping strategies / skills and demographic variables of clients were determined using one way ANOVA. A significant relationship ($P<0.05$) were found between the patients age, occupation and duration of the getting treatment in de-addiction centre. In present study the most common ways of coping through which family members cope with substance addiction of patient were tolerating and engaging coping strategies used whereas similar findings were observed in the study conducted by Orford J, Velleman R, et al (1998) in which they also explored tolerating and engaging coping strategies as most commonly used. Study reported withdrawal as a most common coping strategies used by the care givers of patient which were inconsistence to present study where no such strategy explores [11]. In present study various issues explored such as marital conflict, home / family environment disturbance, financial issues, health and wellbeing related issues, legal issues and job related issues. These finding are consistent with the study conducted by Surendra K.M. *et al.* (2013) where somewhat similar Issues were explored such a disruption of the family routine, financial burden, disruption of the family interaction and family leisure [10].

### Limitations of the study

The present study has its own limitations like any other study. The following are the limitations of the study:

1. The present study explores various coping strategies of families of male patients therefore question should apply in generalization of finding the study only.
2. The sample size is small and sample groups are taken from one de-addiction centre.

The researcher confined the study only to those families who visited the Disha de-addiction centre Kurali

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**CONFLICT OF INTEREST**

**Nil**

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