

Study of Addicted Patients' Families' Coping Strategies and Skills and Development of Patient-Based Family Intervention Program

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Abstract: Coping strategies are the behavioural and psychological efforts individuals use to manage or reduce stress. In families affected by substance abuse, addiction is often concealed both within and outside the family, leading members to adapt coping strategies to preserve family functioning. This study used a descriptive research design to examine coping strategies used by families of individuals with substance use disorders and to develop a patient-centred family intervention program. Guided by the Stuart Stress Adaptation Model, data were collected from 50 purposively selected family members through a structured interview schedule and analysed using descriptive and inferential statistics. Findings revealed that families employed multiple coping strategies. The most common was planning related to managing the illness (86%), followed by instrumental social support (84.5%) and venting of emotions (83%). Other frequently used strategies included engaging in competing activities, religious coping, emotional support, and active coping. Less common strategies were self-restraint, substance use, denial, and humour. One-way ANOVA revealed significant associations ($p < 0.05$) between coping strategies and patients' age, occupation, and treatment duration. Open-ended responses highlighted concerns such as marital conflict, financial burden, health issues, and legal problems. Based on these findings, a family intervention program and educational booklet were developed to support caregivers.

Keywords: Coping Strategies; Coping Skills; Substance Abuse; Family Intervention; Family Caregivers; Stress Adaptation; Social Support; Religious Coping; Family Functioning; Emotional Support; Active Coping.

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1. Introduction

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Addiction is defined as a state of repeated or long-term intoxication that is harmful to both the individual and society, resulting from continuous use of a substance, whether natural or synthetic. The term "addiction" encompasses both dependence and habituation [8]. It is a condition that arises when a person consumes a psychoactive substance (such as alcohol, nicotine, or cocaine) or engages in an activity that may initially bring pleasure but eventually turns into a compulsive behaviour that disrupts everyday responsibilities, including work, relationships, and health [9]. Often, individuals struggling with addiction may not recognise that their actions are out of control or negatively impacting themselves and others. Addiction causes internal changes within a person, and over time, the individual begins to behave in ways that reflect these alterations. As the condition progresses, it transforms into a way of life [9]. People who experience emotional pain, grief, loss, or trauma may be more likely to develop addictive behaviours, such as dependency on alcohol or drugs, to cope. To escape distress, individuals often pursue experiences that increase pleasure and avoid discomfort. For some, the use of substances becomes one of those coping mechanisms [13]. Since researchers cannot fully control the balance between peace and pain in life, most people learn to adapt or find contentment within this cycle; however, people with an addiction attempt to control these inevitable experiences. Initially, alcohol or drugs may help them mask the pain and evoke positive emotions, but as usage continues, it leads to a progressive deterioration. In essence, addiction is characterised by a relentless pursuit of happiness or an attempt to avoid emotional suffering. Regardless of the substance involved, people with an addiction often develop a psychological "relationship" with the drug that brings about a shift in mood [12].

The act of using substances to achieve this mood change is known as acting out. Through this behaviour, the person with an addiction seeks feelings of excitement, fantasy, or calmness. However, the temporary mood alteration creates an illusion of control, further reinforcing the cycle. The misuse of alcohol and other substances has become a growing social concern, contributing to the breakdown of individuals, families, and communities. Substance abuse imposes a heavy financial and emotional burden, not just on the user but also on their families and society at large [10]. The cost includes both direct expenses—such as hospital treatments, compensation claims, and criminal justice expenditures—and indirect losses, such as reduced productivity due to illness, premature death, inefficiency at work, and increased unemployment. Emergency departments report that between 7,000 and 22,000 patients annually are treated for alcohol-related issues, and around 10–30% of emergency visits are attributed to alcohol misuse. According to Rutter [7], family dynamics play a significant role in both the development and continuation of alcohol and drug-related problems. Disruptions in family relationships are closely linked to substance addiction [14]. Families affected by alcoholism often exhibit behaviours such as emotional extremes, absence of normal behavioural models, and imbalanced power dynamics. Psychological issues within these families may include stigma, emotional detachment, guilt, and intense cravings. From a biopsychosocial perspective, substance use and abuse are influenced by biological, psychological, and social factors. Biologically, individuals may have a genetic predisposition or resilience, and tolerance levels can vary with age and development.

Psychological components involve personality traits, emotional regulation, cognition, expectations, and behaviour. Social influences encompass parenting styles, peer groups, life stressors, educational environments, community conditions, and cultural norms. Parental influence may impact substance use behaviour, though it is not always substance-specific. Coping strategies refer to the deliberate behavioural and psychological efforts individuals use to manage, tolerate, or lessen the impact of stressful situations. These strategies generally fall into two main categories: Problem-focused coping, which involves actively working to change or address the source of stress, and emotion-focused coping, which centres on managing the emotional response to the stressor. Active coping strategies aim to alter the stressor itself or reframe one's thinking about it. In contrast, avoidant coping strategies often involve escapist behaviours—like substance use—or psychological withdrawal, which prevent individuals from confronting the stress directly. Coping, in essence, means making a conscious effort to resolve personal or interpersonal challenges and to reduce or manage the stress associated with them. The effectiveness of these efforts depends on several factors, including the nature of the stressor, the individual's personality, and the specific circumstances in which the stress occurs. Multiple studies have shown that religion can be a powerful coping tool in times of stress. According to Pargament's [5] research, between 30% and 90% of individuals rely on religious practices when facing challenges, depending on the context and the population studied. As stress levels increase, especially when situations seem hopeless or uncontrollable, religious coping strategies are more frequently used.

Similarly, Spilka et al. [6] found that the more threatened individuals feel, the more likely they are to turn to faith-based coping mechanisms. While every family is unique, certain common traits are often observed in households where an adult struggles with substance abuse. These families often feel unstable, with unclear roles, arbitrary rules, and a sense that change is difficult or overwhelming. Conflicts, irrational thinking patterns, and even emotional or physical abuse may be present. Often, the substance use becomes a closely guarded family secret, denied internally and hidden from outsiders. In response to the turmoil caused by addiction, families tend to shift their coping behaviours and alter their shared belief systems in an effort to keep the family unit intact. In the Indian context, families play a critical role in the care of individuals with mental health issues, including those with addiction. This is largely due to the cultural emphasis on interdependence and the limited availability of mental health professionals. Family caregivers are those who offer unpaid, ongoing support to relatives in need—whether due to illness, disability, or special needs. Illness often creates a ripple effect, impacting not just the individual but also their close ones through

physical, emotional, financial, and social distress. These consequences are referred to as the caregiver burden and are heavily influenced by the family's coping styles and their capacity to tolerate dysfunctional behaviours.

1.1. Need for the study

Individuals who develop a serious dependence on alcohol or drugs often exhibit behaviours that deeply disrupt family life and negatively affect other family members. Substance misuse can disrupt various family dynamics, including rituals, roles, daily routines, communication patterns, social interactions, and financial stability. It can also lead to issues like domestic violence, child abuse, drunk driving, or the person going missing for extended periods. Globally, it is estimated that 208 million people use illegal substances. According to the United Nations' 2008 World Drug Report, approximately 3.9% of the global population aged 15–64 misuse marijuana. In India alone, an estimated 7.5 crore people are drug dependent, with the issue expanding into semi-urban and underdeveloped regions. National survey data reveal that among individuals aged 12–18, substance use prevalence rates include alcohol (21.4%), cannabis (3%), opiates (0.7%), and any illicit drug (3.6%). Specific high-risk populations include commercial sex workers, transport workers, and street children. Punjab is facing a major drug crisis, with the second-highest rate of drug addiction in the country, according to a recent UN report. A study by Guru Nanak University found that 73.5% of individuals aged 16–35 in the region are addicted. Another estimate suggests 50–60% of youth in this age group are using drugs, with Amritsar particularly affected, where over 70% of young people reportedly abuse readily available substances. Heroin is often used by those who can afford it, while others use cheaper alternatives.

Additionally, 48% of Punjab's farmers and labourers are considered addicted. In rural areas around Amritsar, many men in their 20s and 30s have died from addiction-related complications. In one school, around 70% of students had lost a parent to drug use. During the last election, law enforcement reportedly seized 700,000 litres of alcohol, 150 kg of heroin, and 30 tons of opium poppy husk in the state. How family members perceive stress and how they respond to it plays a major role in determining their mental health. Many relatives express a need for counselling and treatment, recognising the emotional toll of living with someone who is addicted. This highlights the importance of stress management strategies and brief interventions to modify coping styles and minimise the psychological impact on families. Families of individuals with addiction frequently live with shame, guilt, and a constant desire to help their loved one. A cross-cultural research study revealed that families of people with an addiction experience deep worry and require significant support. One major concern is the mental instability of the addicted person, as they may exhibit erratic behaviour, ranging from depression and apathy to severe symptoms like hallucinations or blackouts. Relatives also experience anxiety over changes in the addicted person's approach to work or school, such as dropping out, losing interest in healthy pursuits, or becoming unmotivated and aimless. Parents especially worry about lost educational opportunities, a lack of direction, and irresponsibility.

Financially, the burden of addiction is considerable—many people with an addiction spend beyond their means, sell belongings, or even turn to theft or sex work to sustain their habits. Another concern is the shift in social circles the addicted individual becomes involved with after developing a dependence. It is essential to focus on families affected by addiction for two key reasons. First, these family members often display significant stress-related symptoms, indicating a need for direct support. Second, involving families in the treatment process of addicted individuals has been shown to improve recovery outcomes. The review of existing literature, the investigator's professional experiences, and a personal interest in the subject motivated the decision to pursue this study. It was observed that limited research exists on this topic, highlighting the need for a comprehensive investigation into the coping mechanisms and strategies used by families of individuals with addiction. Furthermore, it underscores the urgency for developing family-based intervention programs tailored to the needs of these caregivers. Families affected by addiction often become painful and chaotic environments, where both children and adults may experience emotional trauma. The emotional, psychological, and behavioural patterns within the household often swing to extremes, resulting in intense stress for all members. Normal family life is regularly interrupted by unexpected or alarming incidents related to substance use. Communication often becomes confusing, as what is said doesn't align with what is felt or seen.

To preserve a sense of order, both the substance user and the family members may engage in denial, manipulation, and distortion of reality. As a result, the entire family structure becomes consumed by the addiction, which starts to take control. In such families, minor issues are blown out of proportion, while serious problems are minimised. Emotional pain is frequently suppressed rather than acknowledged. When substances like alcohol or drugs enter the picture, the family's ability to regulate emotions and maintain healthy behaviour patterns is severely compromised. To maintain some form of balance, the family adjusts as a collective unit, often adopting dysfunctional roles and coping patterns. Over time, family members may become so entangled in the chaos that they lose sight of what is normal [16]. Their focus shifts to concealing the addiction from themselves, their children, and the outside world. The family's sense of trust, stability, and predictability deteriorates, as promises are broken and key figures become unreliable. Both adults and children may begin to question whom or what they can rely on. As the addiction progresses, these dysfunctional ways of interacting become deeply ingrained. Some family members withdraw

emotionally, while others may compete for attention and affection. In many cases, older siblings step into caregiving roles, becoming "parentified" children who take on responsibilities well beyond their years.

1.1.1. Assumptions

- Family caregivers perceive and experience burden in caring for addicted relatives.
- Families of addicted patients often go through disruption of routine, interactions, finances, and leisure time.
- Chronic stress reduces the ability to cope with problems.
- Families living with an addicted patient have a dispersed range of resilience.

1.1.2. Delimitations

- Families of those patients admitted to Disha De-Addiction Centre, Kurali.
- Families of male patients only.

2. Review of Literature

This paper presents selected studies related to the objectives of the proposed study. A review of research and non-research literature relevant to the study was undertaken, which helped the investigator gain deeper insight into the problem and learn about past efforts [1]. A literature review involves the systematic identification, location, and scrutiny of written materials relevant to a research problem. The research literature was reviewed to broaden understanding and gain insight into the problem under study. The 2024 study on One-on-One Psychosocial Intervention for Caregivers focused on evaluating the effectiveness of an individualised support program for family members caring for individuals with substance use disorders [2]. Conducted as a pilot randomised controlled trial (RCT) in India, the intervention comprised 12 structured sessions tailored to address caregivers' psychological, emotional, and practical challenges. The study revealed that participants who received the intervention experienced significant improvements in psychological well-being, with marked reductions in stress, anxiety, and emotional burden [3]. Additionally, caregivers demonstrated enhanced coping abilities, cognitive functioning, and a better understanding of addiction-related behaviours. The findings highlight the potential of targeted, one-on-one psychosocial interventions to empower caregivers by improving their mental health, building resilience, and enhancing their capacity to manage the demands of caregiving in addiction-affected families. The Kershaw et al. [12] was a mixed-method pilot study conducted in Australia and New Zealand to support families affected by alcohol and other drug (AOD) misuse. The program aimed to assess the needs, experiences, and barriers faced by family members while providing a digital platform for resilience-building.

Findings revealed that participants were under high stress, with 68% reporting financial strain and 75% experiencing disruptions in their social lives due to a loved one's substance use [13]. While 64% had some form of social support, a significant number (58–60%) had not received help from healthcare or social service professionals. Only 45% of participants had accessed formal services, mainly through counselling, general practitioners, or support groups like Al-Anon. Major barriers to help-seeking included stigma, cost, lack of time, and negative past experiences with services. Despite these challenges, participants expressed a strong interest in structured, evidence-based, and accessible online support, highlighting the need for tailored, family-centred digital interventions [5]. The 2022 literature review on Coping and Support in Addiction-Affected Families revealed that families living with a member who has a substance use disorder often experience significant emotional, social, and financial stress [6]. The review found that family members commonly adopt a range of coping strategies, broadly categorised as problem-focused, emotion-focused, and avoidant. Problem-focused strategies include actively seeking help, setting boundaries, or engaging in treatment planning, while emotion-focused coping often involves seeking emotional support or turning to spirituality and faith to manage distress. Avoidant strategies, such as denial, withdrawal, or minimising the problem, were also reported, though these were often linked to increased psychological burden. Many family members expressed a need for more structured psychosocial support, including access to professional counselling and peer-led support groups [7].

The review highlighted that stigma, lack of awareness, and social isolation frequently prevent families from seeking timely help. It emphasised the importance of incorporating family-focused interventions and education to empower caregivers, improve communication patterns, and promote healthier family dynamics. Overall, the findings stress the urgent need for accessible, culturally sensitive support systems that not only assist the addicted individual but also address the complex needs of the entire family system. Rushton et al. [14] examined 19 studies focusing on interventions for families affected by substance use. The review revealed that both individual and group-based psychosocial interventions are effective in reducing psychological distress among family members of people with substance use disorders. Specifically, the interventions led to a significant decrease in depression, stress, and emotional burden, with moderate effect sizes observed. Additionally, these programs improved family functioning, enhanced problem-solving skills, and promoted healthier coping mechanisms. Some interventions also showed positive outcomes in areas such as communication patterns, emotional regulation, and caregiver

resilience. Overall, the review concluded that structured psychosocial interventions could play a vital role in improving the mental health and well-being of family members, while also contributing indirectly to better treatment engagement and outcomes for the addicted individuals themselves [8]. Mindfulness-Oriented Recovery Enhancement (MORE) is an evidence-based therapeutic intervention developed to help individuals struggling with addiction, stress, and chronic pain. Over the past decade, multiple clinical trials have demonstrated its effectiveness in improving emotional regulation, reducing substance cravings, and enhancing psychological well-being. MORE combines mindfulness training, cognitive-behavioural therapy (CBT), and principles of positive psychology. The intervention teaches individuals to become aware of triggers, manage cravings by reappraising negative thoughts, and cultivate positive emotions through techniques like savouring and gratitude [9]. Research has shown that participants in MORE programs report significant reductions in opioid misuse, alcohol and nicotine dependence, and symptoms of anxiety and depression. Functional MRI studies have also indicated that MORE may positively alter brain responses associated with reward and self-control. Importantly, the skills taught in MORE—such as present-moment awareness and emotional self-regulation—are also beneficial for family members of addicted individuals, making it a promising framework for both direct and indirect support in addiction recovery [10].

3. Methodology

The methodology provides a brief description of the steps undertaken to conduct this study. The research approach is an important element of research design. It indicates the basic procedure for conducting the research. The research approach provides a realistic view of how research is conducted and is a useful framework for designing, implementing, and evaluating studies. The choice of an appropriate method depends on the study's purpose and its objectives. A non-experimental approach was chosen to explore the coping strategies and skills adopted by families of addicted patients and the development of a patient-based family intervention program.

3.1. Population

The population is the entire set of individuals who meet the sampling criteria. In the present study, the population consists of family members of addicted patients who were visiting the De-addiction centre Kurali at the time of data collection.

3.2. Criteria for Selection of Sample

3.2.1. Inclusive Criteria

Inclusion criteria are characteristics that prospective subjects must have to be included in the study:

- Family members of addicted patients admitted to Disha De-Addiction Centre, Kurali.
- Family members above the age of 18years.
- Family member attending a de-addiction centre and willing to participate in the study.
- Family members of male patients.

3.2.2. Exclusion Criteria

Sampling criteria specifying the characteristics that a population does not have. In this study, it refers to:

- Family members of patients with a history of major psychiatric disorder or physical illness.

3.3. Setting

The setting is the physical location and condition in which data collection takes place in the study. The study was conducted at the Disha De-addiction Centre in Kurali. This is a 50-bed centre now named Faith Foundation Rehabilitation Centre. The Punjab government approves this and has a provision for the indoor treatment of patients with various psychoactive substances.

3.4. Development of Tool

Tools are the procedures or instruments used by the researcher to collect data. The tool was prepared in accordance with the study's objectives. The following steps were taken before developing the tool:

- Review of literature provided adequate content for the tool preparation.
- Expert opinion of experts from the mental health nursing department.

- An interview schedule was developed to assess the coping strategies and skills adopted by families of addicted patients.

3.5. Testing of Tool

Validity is the degree to which an instrument measures what it is supposed to measure.

3.5.1. Content Validity

Content validity refers to the extent to which the items of an instrument adequately represent the universe of content. The prepared tool, objectives, blueprint, and criteria rating scale were given to 8 experts from the Department of Psychiatric Nursing. The experts were requested to give their opinion on the adequacy, relevance, and appropriateness of the content using a criterion rating scale with columns for not relevant, somewhat relevant, quite relevant, and highly relevant, along with a remark. The final draft of the tool included an interview schedule with 16 items to collect demographic data and 41 items to assess the coping strategies and skills adopted by families of addicted patients. And there are three open-ended questions about the problem, the behaviour, and the skills experienced or learned. The adapted tool was translated into Punjabi by a language expert.

3.5.2. Reliability of the Tool

Reliability of an instrument is the degree to which it consistently measures the attribute it is intended to measure. The tool was used on 10 family members of addicted patients to determine the reliability and internal consistency of the instrument. The tool's reliability was assessed using Karl Pearson's correlation coefficient, which indicated high reliability ($r = 0.76$).

3.5.3. Pretesting of the Tool

Pretest is the trial administration of a newly developed instrument to identify flaws or time requirements. The tool was pretested on five subjects who met the inclusion criteria. The subjects clearly understood the instrument's language. The interview schedule was completed in an average of 30 min. The last tool was not changed.

3.6. Description of the Final Tool

The Final tool (interview schedule) for identifying the coping strategies and skills consisted of two parts:

- **Tool:** Interview schedule to collect the demographic data (16 items).
- **Part 1:** Socio-demographic variables include age, gender, education, occupation, marital status, relationship with the patient, total monthly family income, and interpersonal relationships among family members.
- **Part 2:** Socio-demographic variables of clients include age, education, occupation, marital status, type of addiction, duration of addiction, duration of getting treatment at the De addiction centre, and relapse.

3.7. Process of Data Collection

Before collecting data, the investigator obtained written permission from Disha De-Addiction Kurali and promised to maintain the confidentiality of the subjects and their responses and consents. Data were collected from 50 family members of the addicted patients fulfilling the sampling criteria in March 2015 by using an interview schedule prepared in English and Punjabi. Data collection was concluded with thanks to all family members for their participation and thanks to all faculty members for their full cooperation and guidance. The data collected were collated for analysis.

3.8. Plan of Data Analysis

Data analysis is the organisation and synthesis of data from research. A goal was to analyse data. The data collected by the researcher would be transferred to a master sheet prepared for each section of the tool:

- Descriptive and inferential statistics would be used to achieve the study's objective.
- The demographic variables would be analysed using frequency and percentage.
- The coping strategies and skills adopted by family members of addicted patients would be analysed using frequency, frequency percentage, mean, and standard deviation.
- The relationship between demographics and coping strategies would be assessed.

4. Analysis and Interpretation

Data collected to explore the coping strategies and skills adopted by families of addicted patients and the development of a patient-based family intervention program. Analysis of data involves translating information collected during research papers into interpretable, convenient, and descriptive terms to draw inferences using statistical methods. The data were analysed using descriptive and inferential statistics, consistent with the study's objective. Section A: Frequency and percentage distribution of selected demographic variables.

4.1. Sample Characteristics

The sample consists of 50 family members selected through purposive sampling. The underlying criteria for the selection were family members of addicted patients visiting Disha De Addiction Centre, Kurali, at the time of data collection. Personal information includes the socio-demographic characteristics of the addicted patient's family members, the patient's personal characteristics, and information about family dynamics:

- Personal characteristics of subjects include Age, Gender, Education, Occupation, Marital status, Relationship with the patient, Total monthly family income, and Interpersonal relationships among family members.
- Personal characteristics of clients include Age, Education, Occupation, Marital status, Type of addiction, Duration of addiction, Duration of getting treatment at the de-addiction centre, and relapse.

Table 1: Distribution of subjects as per socio-demographic variables, N=50

No.	Variables	Frequency	Percentage
1	Age (in years)		
	18-25	05	10
	26-35	13	26
	36-45	11	22
	46-50	13	26
	Above 50	08	16
2	Gender		
	Male	19	38
	Female	31	62
3	Educational Status		
	Upto5th	05	10
	Upto8th	01	02
	Upto10th	13	26
	Upto12th	09	18
	Graduation and above	22	44
4	Occupation		
	Unemployed	23	46
	Government job	09	18
	Private job	09	18
	Business	09	18
5	Marital Status		
	Married	39	78
	Unmarried	10	20
	Divorced	00	00
	Widow	01	02
	Separated	00	00
6	Relation with the Patient		
	Brother/sister	18	36
	Spouse	6	12
	Parent	21	42
	Grandparent	00	00
	Son/daughter	02	04
	Other specify	03	06
7	Monthly Family Income		

	1000-9000	02	04
	10,000-19000	03	06
	20,000-29,000	12	24
	30,000-39,000	12	24
	Above 40,000	21	42
8	Interpersonal Relationship Among Family Members		
	Good		
	Somewhat good	32	64
	Not good	18	36
		00	00

The main demographic and socio-economic characteristics of the subjects are summarised in Table 1. Most participants were aged 26-35 and 46–50 years (26% in each group), and 62% were female. A large proportion (44%) were graduates or above, and most participants (46%) were unemployed. Most were married (78%) and were mainly parents (42%) or siblings (36%) to clients. In the income category, most of the subjects (42%) had a monthly income of more than ₹40,000. Interpersonal relationships were generally positive, with 72% reporting good family relationships.

4.1.1. Type of Addiction

Addiction wise distribution shows that most of the clients(16%) consumed heroin, second most(14%) of the clients addicted to alcohol and smack, 12% of the clients using multiple drugs, 10% of the clients addicted to smack, injection and poppy flower, 8% of the clients consumed cannabis and smack,6% of the clients used injections, opium, alcohol and smack, equal number of patients (4%) were addicted to alcohol and opium, alcohol and tobacco and opium, equal number of clients(2%) were addicted to smack: Alcohol and cannabis, alcohol, smack and bhuki, alcohol, tobacco and tablets (Figure 1).

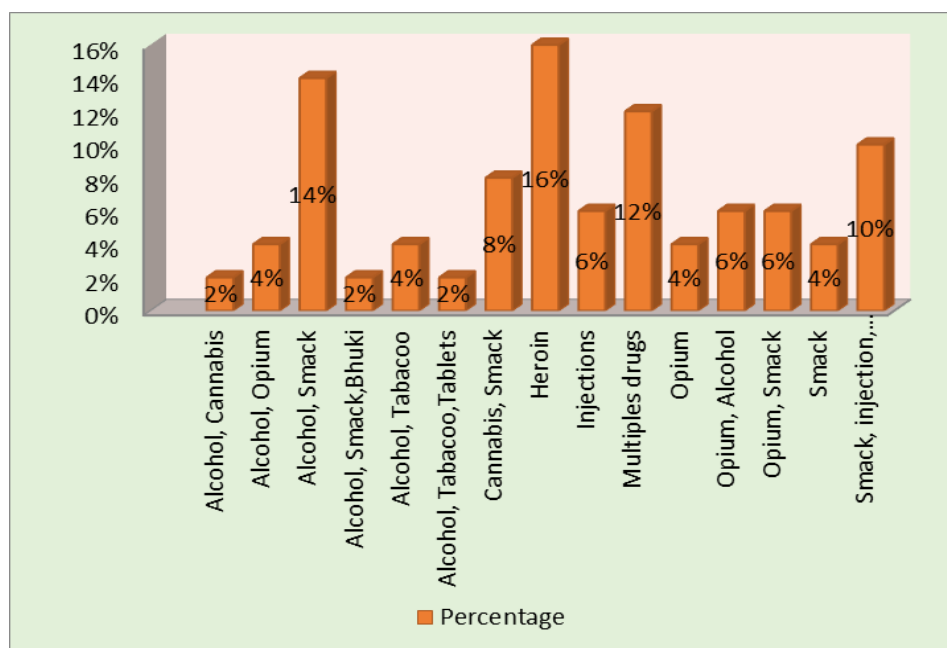


Figure 1: Bar diagram showing the percentage distribution of the clients according to the type of addiction

The majority (40%) of the clients were receiving treatment at de de-addiction centre for 6 months, and 22% for over 1 year. In contrast, an equal number of clients (22%) are receiving treatment at the de-addiction centre for 3 months, and 16% of the patients are receiving treatment at de de-addiction centre for 1 month (Figure 2). The results show that the subjects used coping strategies at the overall mean level of 68.84% (mean \pm SD: 112.90 \pm 68.84). Planning was the most used strategy (86%; 13.76 \pm 2.31), followed by instrumental social support (84.50%; 6.22 \pm 1.94). Frequent venting of emotions (83%; 9.96 \pm 2.15) and religious coping (78.33%; 9.40 \pm 2.40) were also reported, further indicating their role in stress management. The findings show that 77.75% of subjects used emotional support (friends, discussion) as a coping strategy (6.22 \pm 1.94), while 76.83% adopted active coping (direct efforts) (9.22 \pm 2.23).

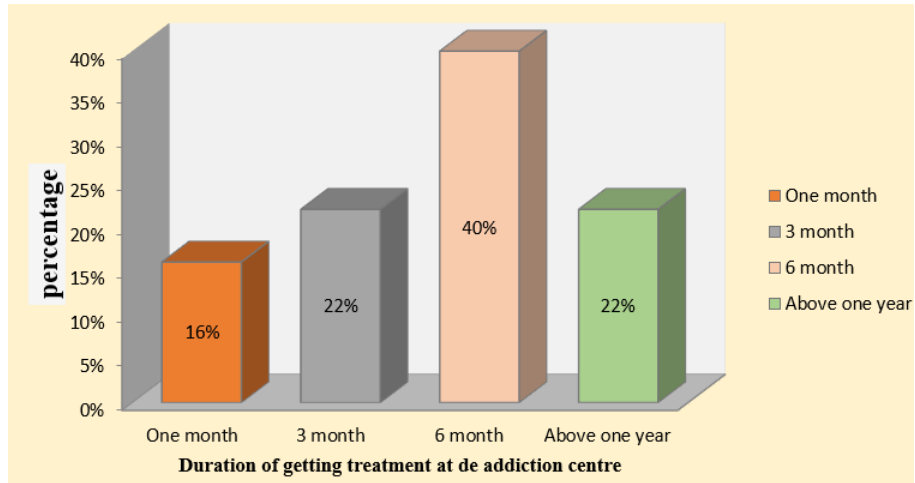


Figure 2: Bar diagram showing the percentage distribution of the clients according to the duration of getting treatment at the de-addiction centre

Acceptance of the situation was reported by 70% (8.50 ± 1.99), and 65.83% used positive reinterpretation and growth (7.90 ± 2.16). Mind diversion strategies were used by 64.16% (7.70 ± 1.40), and 60% reported behaviour disengagement (4.80 ± 1.91). Self-restraint was used by 49.25% of subjects. However, 45% relied on substance use (3.60 ± 1.82), and 42.6% reported denial as a coping strategy. Humour was the least used strategy, reported by only 33.5% of subjects (Figure 3).

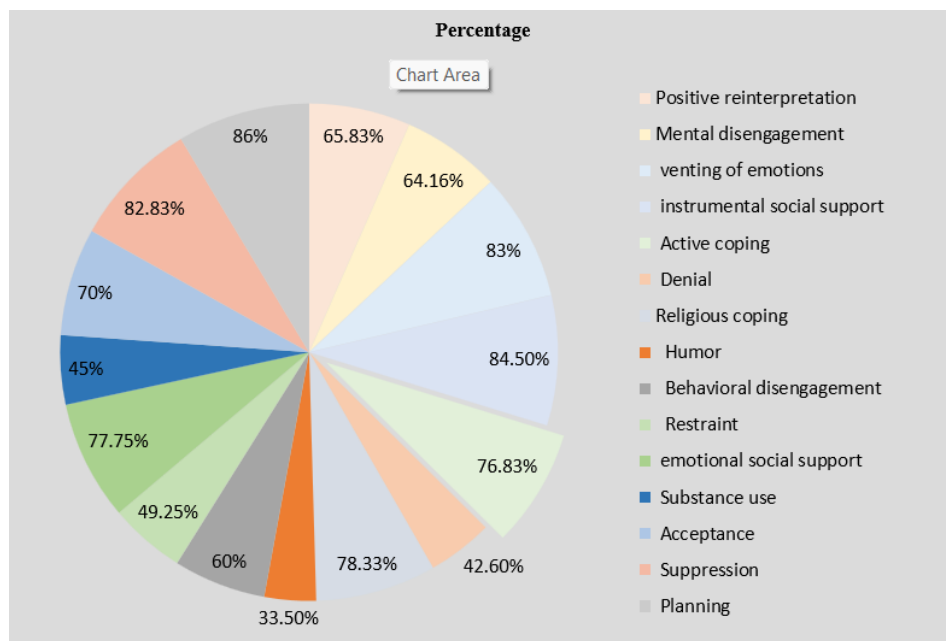


Figure 3: The pie diagram shows the percentage of the subjects according to domains

4.2. Item Analysis

Table 2 reveals that (46%) of subjects positively see the client's illness.

Table 2: Frequency distribution of responses of the subjects regarding the use of positive reinterpretation and growth, N=50

No.	Items	No. of Respondents			
		I usually don't do this at all	I usually do this a little bit	I usually do this a medium amount	Usually do this a lot
	Positive Reinterpretation and Growth				

1	I try to see his illness in a different light, to make it seem more positive.	3	6	18	23
2	I look for something good in what is happening with my patient.	13	18	12	7
3	I learned something from my experience with him.	9	21	9	11

(14%) Subjects focus on the positive aspects of their clients. (22%) Caregivers see their clients' illness as an opportunity for learning.

Table 3: Frequency distribution of responses of the subjects' use of denial, N=50

No.	Items	No. of Respondents			
		I usually don't do this at all	I usually do this a little bit	I usually do this a medium amount	I usually do this a lot
1	I say to myself, "This isn't real"	31	8	4	7
2	I refuse to believe that it has happened to my relatives.	37	2	5	6
3	I act as though it hasn't even happened	31	6	6	7

Table 3 reveals that the highest (31%) number of subjects don't say this is not real. (37%) Subjects refuse to believe it has happened to my relatives (31%) and think it has not happened.

Table 4: Relationship between coping strategies and demographic variables of subjects N=50

No.	Demographic Variable	N	Mean±S.D	Z-value	P- Value
1	Age in years				
	18-25	5	110.0±12.4	.560	.693 NS
	26-35	13	112.3±12.6		
	36-45	11	113.1±8.31		
	46-50	13	116.3±8.09		
Above 50	8	109.6±15.4			
2	Gender				
	Male	19	112.4±10.8	-.238	.813NS
	Female	31	113.1±11.3		
3	Education				
	up to the 5th	5	113.4±14.5	1.60	.191NS
	up to 8 th	1	106.0		
	up to 10 th	13	115.3±8.03		
	up to 12 th	9	118.8±7.78		
graduate and above	22	109.2±12.2			
4	Occupation				
	unemployment	23	114.8±10.0	.701	.556NS
	Govt job	9	108.7±16.3		
	Private job	9	113.5±7.93		
Business	9	111.4±10.3			
5	Marital status				
	married	39	112.6±10.8	.710	.497NS
	unmarried	10	112.7±11.9		
Widow	1	126.0			
6	Relation with the patient				
	brother/sister	18	111.0±10.6	1.05	.388NS
	spouse	6	114.4±10.4		
	parent	21	113.8±11.8		
	Son/daughter	2	125.5±.70		
other	3	107.0±9.5			

7	Total monthly family income				
	1000-9000	2	116.0±14.1	1.69	.168NS
	10000-19000	3	125.3±.57		
	20000-29000	12	114.0±7.78		
	30000-40000	12	114.3±10.3		
	>40000	21	109.3±12.5		
8	Interpersonal relationship				
	Good	36	111.9±11.3	.906	.346NS
	Somewhat good	14	115.2±10.2		

Table 4 shows that there is no significant relationship between coping strategies and the subjects' demographic variables.

Table 5: Relationship between Coping Strategies and Demographic Variables of Clients (N = 50)

No.	Demographic Variable	N	Mean±S.D	Z-Value	P- Value
1	Age in Years				
	<18	4	108.5±16.6	1.99	.087*
	19-25	7	109.1±12.5		
	26-30	6	119.5±6.74		
	31-35	16	115.0±6.96		
	36-40	11	114.9±11.9		
	41-46	2	114.5±7.77		
>46	4	99.2±12.2			
2	Educational Status				
	up to the 5 th	9	115.3±6.50	.765	.554NS
	up to 8 th	4	110.2±14.7		
	up to 10 th	11	108.9±12.5		
	up to 12 th	12	116.0±9.8		
Graduate and above	14	112.5±12.2			
3	Occupation				
	Unemployed	29	113.6±10.6	3.68	.032*
	govt job	3	97.0±14.0		
Business	18	114.2±9.75			
4	Duration of Addiction				
	<6 months	4	112.0±12.2	.538	.587NS
	6 months to 1 year	17	115.1±11.9		
>2 years	29	111.6±10.5			
5	Duration of Getting Treatment in a De-Addiction Centre				
	one month	8	107.6±13.9	3.84	.015*
	3 months	11	117.8±9.13		
	6 months	20	116.0±5.94		
	> 1 year	11	106.0±13.8		
6	Relapse				
	Never	21	114.5±12.0	1.77	.164NS
	one time	6	117.5±4.03		
	two times	11	113.8±6.16		
	three or more	12	106.9±13.5		

Table 5 shows significant correlations between clients' age, occupation and duration of treatment at the de-addiction centre with coping strategies and skills. The calculated values (age: 1.99; occupation: 3.68; treatment duration: 3.84) exceed the table values at the 5% level, indicating statistically significant associations.

5. Discussions and Findings

This section discusses the study findings in relation to the research objectives and the literature. 50 samples were studied. The coping strategies used by family members of the substance-addicted patients were planning, instrumental social support, and

venting of emotions. Denial and humour were the least used strategies. Carers also reported serious challenges, including marital conflict, family disruptions, financial and work issues, health issues, and legal issues. These findings led to the development of a family intervention programme and an informational booklet. One-way ANOVA revealed a significant relationship ($p < 0.05$) between coping strategies and patients' age, occupation, and treatment duration, indicating the need for targeted carer support. According to Orford et al. [1], the main coping styles employed by family members in the present study were tolerating and engaging. However, unlike Orford et al.'s study [1], researchers did not observe withdrawal. The carers reported key issues such as marital conflicts, a disturbed family environment, financial difficulties, health concerns, and job-related problems; these are consistent with the findings of Mattoo et al. [2]. A majority (62%) reported financial strain and disruption to their home lives, as did Gupta et al. [3]. An intervention was provided to carers using an information booklet. However, this study did not have any formal therapeutic intervention, unlike Kumar and Thomas [4]. The investigator used an exploratory approach to explore the various coping strategies and skills adopted by families of addicted patients. Purposive sampling technique was used to select 50 family members (caregivers) of the psychoactive substance addicted patient who are visiting Disha De- Addiction Centre, Kurali. The following tool was used for data collection:

- **Tool I:** Interview schedule to collect the demographic data.
- **Tool II:** Interview schedule to explore the coping strategies and skills adopted by families of addicted patients.

A pilot study was conducted on 10 family members of patients with substance abuse to confirm the feasibility of the study. The main study was conducted on 50 family members of addicted patients, and the data obtained were analysed in terms of the objectives using descriptive and inferential statistics. The results showed that most carers were women (62%), married (78%), and had an income of $>₹40,000$ (42%). Among the patients, 36% were between 31 and 35 years of age, 58% were addicted for more than one year, and 66% had relapsed. The mean of the coping level was 68.84%. The most common coping strategies were planning (86%), instrumental social support (84.50%), and venting emotions (83%), followed by competing activities (82.83%), religious coping (78.33%), emotional support (77.75%), and active coping (76.83%). The results indicated that 70% of the carers accepted the disease of their relative, 65.83% of them used positive reinterpretation, 64.16% used mental disengagement, and 60% used behavioural disengagement. Self-restraint was reported by 49.25%, whereas 45% reported substance use, 42.6% reported denial, and only 33.5% reported humour. Statistical analysis (t-test and ANOVA) revealed a significant association ($p < 0.05$) between coping strategies and patients' age, occupation, and treatment duration. Challenges faced by carers include marital conflict, disturbed family environment, financial issues, work-related issues, health issues and legal issues. Overall, the most commonly used coping strategies were planning, instrumental social support, and venting emotions.

6. Implication for Nursing

The present study was conducted to explore the coping strategies and skills adopted by family members of addicted patients. Several implications for nursing practice, education, administration, and research can be drawn from the study's findings. The study's findings have several implications for nursing practice, education, research, and administration. The study's findings were applied across different areas, including nursing practice, nursing administration, and Nursing research. The study's findings have several implications, which are discussed in the following sections.

6.1. Nursing Practice

There is a need for patients with substance abuse to receive prescribed treatment to prevent relapse, and families of these patients play a vital role in patient recovery. Coping strategies used by families are a predictive indicator for recovery. Families of these patients may lack knowledge or skills or may not identify the correct strategies to address the situation. So the nurse plays a key role in working with such families, helping them cope effectively while implementing a patient-centred family intervention program. A mental health nurse can improve the quality of life among family members and also encourage patients in a self-development program. The investigator-developed patient-based family intervention program can be used by families, health workers, nurses, and even patients to address their problems.

Given the importance of extended care, the nurse role has now shifted from hospital-based to community mental health nursing. Where the expended care facilities are available. The community mental health nurse follows up with the community and the patients. She may be able to understand family problems related to substance abuse and treatment compliance, where she can use a patient-based family intervention approach to provide culturally sensitive nursing care. In the present study, families of these patients reported many problems that not only affect their coping strategies but also the well-being of the family members. Hence, nurses need to provide health education and make patients aware of the importance of family involvement in patient care, especially to prevent relapse. The role of a nurse is educational and supportive, helping increase self-care and family support.

6.1.1. Nursing Education

Nurse educators need to be oriented to the problem of substance abuse and associated problems. They only educate their students about the extent of the problems. So, the student can also be prepared to address this while working with their patients and their families. They need to learn more about culturally based family intervention programs. At present, the use of these patient-based family intervention programs is. Hence, nursing students should be taught the importance of these interventions. To improve the mental health of the community.

6.1.2. Nursing Administration

In India, the standard of care for mental health nursing has not been implemented properly. It was also observed that there is a serious capacity of treatment protocol for patients with substance abuse, and it is more like Crestodiol care than rehabilitation. The present study emphasises the involvement of families of patients with substance abuse in their treatment. The administrators of various de-addiction centres can use patient-based family intervention programs to provide uniform evidence-based care to their clients. Further, an in-service education program can be organised for health personnel working for various de-addiction centres.

6.1.3. Nursing Research

The present study explores various coping strategies and problems experienced by family members that are considered during treatment. There is a need to conduct further research in this area to identify the various problems patients and their families experience. This study also revealed the need for a patient-based family intervention program. Hence, a feasibility study should be conducted for this intervention.

6.2. Recommendations

Based on the study's findings, the following recommendations are offered for further research:

- Based on the findings, a similar study can be carried out across different community settings.
- An experimental study can be carried out to determine the effectiveness of a patient-based family intervention program.
- A similar study can be conducted with large samples.
- Coping strategies and skills of wives of psychoactive substance addicted patients can be studied.
- A similar study can be conducted on families of female patients.

7. Conclusion

The present study provides valuable insights into the coping strategies and skills adopted by families of individuals struggling with psychoactive substance addiction. It was found that families commonly employ a range of coping mechanisms, with the most prevalent being planning for illness management, seeking instrumental social support, and venting emotional distress. Additional strategies included religious coping, emotional and active coping, acceptance, positive reinterpretation, mental disengagement, and, to a lesser extent, self-restraint, denial, humour, and even substance use. The analysis revealed a statistically significant relationship between caregivers' coping strategies and certain patient demographic variables, namely age, occupation, and duration of treatment at the de-addiction centre. These findings emphasise that caregivers' coping approaches are not only diverse but also influenced by contextual and situational factors. Furthermore, open-ended responses highlighted pressing concerns, including marital conflict, a disrupted home environment, financial strain, health issues, job instability, and legal problems. In response to these concerns, a patient-based family intervention program was developed and distributed as an informational booklet. The study underscores the critical role families play in managing addiction and the necessity of equipping them with appropriate support and structured interventions. The results advocate for the integration of family-focused strategies in addiction treatment and for empowering caregivers with coping tools to improve both family well-being and patient recovery outcomes.

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