ORIGINAL RESEARCH PAPER

Effects of Strength Based Supportive Therapy on Family Functioning and Coping among Persons with Alcohol Dependence Syndrome

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ABSTRACT

Background: Alcohol dependence is a complex behaviour with far-reaching harmful effects on the family, work, society, as well as on the physical and mental health of the individual. Epidemiological studies conducted in India showed that 20-30% of our population is using alcohol at a harmful level. Mental health professionals provide support and understanding of the illness for the affected individual and family members. They work together on planning treatment; provide mutual support and understanding of the disorder. **Aim:** To study the effects of strength based supportive therapy on family functioning and coping of persons with alcohol dependence syndrome. **Methodology:** This was a hospital based intervention study. It had adopted the quasi-experimental before and after with control group research design. Participants were randomly allocated to the experimental and control groups. 10 persons with alcohol dependence syndrome were selected for the study five each person with alcohol dependence syndrome and their family members were assigned in the control group (treatment as usual group; TAU) and five persons with alcohol dependence syndrome and their family members were assigned in the experimental group (treatment as usual positive family intervention group). Family functioning was assessed through McMaster family assessment device Patients were assessed through brief cope. **Result:** The study results indicated a significant improvement in various domains of family functioning in experimental group participants compared to the treatment as usual group. It has also noted improvement in coping among patients. **Conclusion:** strength based supportive intervention useful for the caregivers as well as it also helps in improving coping among person with alcohol dependence syndrome.

Keywords: Strength based supportive therapy, alcohol dependence, caregivers

BACKGROUND

Alcohol dependence is a complex behaviour with far-reaching harmful effects on the family, work, society, as well as on the physical and mental health of the individual. Epidemiological studies conducted in India showed that 20-30% of our population is using alcohol at a harmful level.[1-2] Family interventions provided by mental health professional support and understand the illness of the affected individual and their family members. They work together on planning treatment; provide mutual support and understanding of the disease. A study found that spouses of the individual with alcohol dependence syndrome are affected on many different levels often present with significant rates of mental and physical health problems, communication problems, low social activity and poor marital satisfaction.[3-4]

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Numerous studies found that alcoholics have extensive marital and family problems, and hence positive marital and family adjustment is associated with better outcome. It has been reported that even at the onset and recovery from alcohol dependence, marital and family conflicts and strain may often precipitate and lead to relapses in abstinent alcoholics.[5]

A one year follow-up study on family intervention consisted of 30 inpatients after 10 days of inpatient treatment with a individually matched control group seen nearly half of the patients in both groups expressed unsatisfactory marital adjustment (56.7% in the study group *vs*. 66.7% in the control group) and previous treatment compared to 63.3% of the control group. Cumulative abstinence duration and relapse rate were significantly longer in the study group.[6] A study conducted on substance-dependent patients (N=29) living with a family member other than a spouse were randomly assigned to equally intensive treatments consisting of either behavioural family counselling plus individual-based treatment. Outcome data were collected at baseline, post-treatment, and at 3- and 6-month follow-up. The treatment exposed subsample showed.[7]

A study review base study of randomized clinical trials suggested that different types of spouse involved therapy generally, and Behavioural Couples Therap*y* in particular persons with alcohol dependence syndrome, using the spouse to apply positive contingencies for sobriety-related behaviours leads to more positive outcomes in alcoholism.[8]

A study found that coping behaviour in preventing relapse has led to the implementation of coping skills training as a major component of nearly all empirically supported treatments for alcohol use disorders.[9] A study which stated that only by improving the coping skill on interpersonal environmental factors and intra factors such as stimulus control, confrontation with negative emotions, confrontation with failure and anger, interpersonal conflicts with family members and attendants, identifying risky situation, in general, are specific coping strategy from which person would obtain necessary cognition, behaviour, emotional abilities to confront with the sign of slip starter and relapse.[10]

Aim of the Study

To study the effects of strength based supportive therapy on family functioning and coping of persons with alcohol dependence syndrome.

METHODS AND MATERIAL

This study was a hospital based intervention study. In this study pre and post with control group design has been used. Ten samples who have given informed consent were selected purposively based on the inclusion and exclusion criteria. Five persons with alcohol dependence syndrome (PWADS) and their family members were assigned to the control group (treatment as a usual group; TAU) and five persons with alcohol dependence syndrome and their family members were assigned in the experimental group (treatment as usual + family intervention group) randomly. Tools used for the study were semi-structured interview schedule for the socio-demographic data sheet, Brief Cope Scale,[11] for caregivers General Health Questionnaire-12[12] and The McMaster Family Assessment Device.[13]

The Family intervention started with baseline assessment with the patient and his family members. Then both PWADS and their family members had been given psycho-educated regarding present condition of the PWADS after supportive counselling, communication skill training, systematic family therapy and problem solving techniques, utilization of time taught in approximately 15 sessions, weekly twice for about an hour to family members and PWADS. At the end, post assessment was done with the PWADS and their family members using the same tools used at the baseline. Follow-up assessment was done after three months. After successful completion of the study, participants belonging to control group were also given family intervention. The study was approved by the doctoral research committee of Ranchi Institute of Neuro Psychiatry and Allied Sciences.

RESULT

Table-1 Socio Demographics Profile of PWADS

Variable	Variable Category	Experimental Group	Control Group	df	χ^2
Education	Primary	0(0%)	1(20.0%)	3	.506NS
	Secondary	3(60.0%)	1(20.0%)		
	H. Secondary	1(20.0%)	2(40.0%)		
	Graduation	1(20.0%)	1(20.0%)		
Occupation	Farmer	1(20.0%)	2(40.0%)	4	.615NS
	Government job	1(20.0%)	0(0%)		
	Business	0(0%)	1(20.0%)		
	Private job	2(40.0%)	1(20.0%)		
	Daily labour	1(20.0%)	1(20.0%)		
Marital status	Single	1(20.0%)	1(20.0%)	1	.778NS
	Married	4(80.0%)	4(80.0%)		
Family type	Nuclear	4(80.0%)	3(60.0%)	1	.500NS
	Joint	1(20.0%)	2(40.0%)		
Mother Tongue	Nagpuri	1(20.0%)	1(20.0%)	3	.565NS
	Hindi	3(60.0%)	4(80.0%)		
	Bengali	1(20.0%)	0(0%)		
Domicile	Rural	0(0%)	2(40.0%)	2	.208NS
	Sami-Urban	1(20.0%)	0(0%)		
	Urban	4(80.0%)	3(60.0%)		
Religion	Hindu	3(60.0%)	2(40.0%)	4	.469NS
	Islam	0(0%)	1(20.0%)		
	Sarana	1(20.0%)	2(40.0%)		
	Christian	1(20.0%)	0(0.0%)		

Table- 2a Socio-demographic Profile of Caregivers

Variable	Variable Category	Experimental Group	Experimental Group	df	χ^2
Education	Primary	1(20.0%)	0(0%)	2	.565NS
	Secondary	3(60.0%)	4(80.0%)		
	H. Secondary	1(20.0%)	1(20.0%)		
Occupation	Government job	1(20.0%)	1(20.0%)	3	.572NS
	Housewife	3(60.3%)	3(60.3%)		
	Private job	0(0%)	1(20.0%)		
	Daily labourer	1(20.0%)	0(0%)		

NS= Not Significant

Table 2b Comparison Socio-demographic Variables of Caregivers

Variable	Experimental Group	Control Group	df	Mann Whitney Test	
	Mean± SD	Mean± SD		U value	Z score
Age of Caregivers	29.00 ±4.18	27.60 ± 7.92	8	9.50	-.629NS
Length of Stay	12.00 ± 5.24	10.60 ± 8.44	8	10.50	-.419NS
Family Income	12800 ± 3563.70	10600 ± 4878.52	8	9.00	-.738NS

NS= Not Significance

Table 1 shows the socio-demographic profile of PWADS. Experimental groups and control groups were compared using chi-square test, it is found that there is no significant difference in both groups of participants. Though, the socio-demographic profile of both groups matched. The mean age of PWADS was in experimental group 32.20 ± 5.54 and control group 30.60 ±8.35 years. On Mann Whitney test score (Z=-.314, p≥0.05) there was no significant difference was found between experimental and control group.

Table 2a shows the socio-demographic profile of caregivers of PWADS. In comparison, there was no difference found on education and occupation in the both the group.

Table 3 Pre and Post Intervention Difference on Family Variables between Intervention Group and Control Group

Area of assessment	Experimental Group (Mean ± SD)			Control Group (Mean ± SD)			Mann Whitney Test			
	Pre	Post	Difference (pre-post)	Pre	Post	Difference (pre-post)	Intervention Group Mean Rank	Control Group Mean Rank	U value	Z score
Problem Solving	15.40±1.94	10.40±1.51	5.00±3.31	15.20±2.16	14.80 ±2.58	.400±.54	7.30	3.70	3.50	-1.95*
Communication	23.40±2.70	15.00±2.00	8.40±2.07	21.80±3.83	21.00±4.63	.800±1.78	8.00	3.00	.000	-2.70**
Role	30.40±2.19	25.60±1.51	4.80±2.58	31.80±1.64	30.60±2.88	1.20±2.16	7.40	3.60	3.00	-2.02*
Affective Responsibility	14.60±1.51	10.80±2.38	3.80±3.49	16.00±2.23	14.60±1.51	1.40±3.71	6.20	4.80	9.00	-.742NS
Affective Involvement	19.20±1.64	11.60±1.67	7.60±3.04	19.80±1.92	17.60±2.30	2.20±3.03	7.50	3.50	2.50	-2.12*
Behavioural Control	23.20±2.58	14.20±2.86	9.00±3.24	25.00±4.74	23.00±2.73	2.00±4.47	7.20	3.80	4.00	-1.83NS
General Functioning	32.20±2.77	25.60±1.34	6.60±3.20	32.60±3.36	31.80±5.26	.800±2.38	7.80	3.20	1.00	-2.44**
Total FDA Score	1.58±5.54	1.13±2.16	45.20±6.01	1.62±4.43	1.53±15.50	8.80±16.52	8.00	3.00	.000	-265**
Coping	64.00±7.96	94.80±3.34	-30.80±8.92	64.60±5.58	73.40±8.04	-8.80±13.42	3.40	7.60	2.00	-2.20*

NS= Not Significance, *=Significance at 0.05 & ** =Significance at 0.01

Table 2b shows the comparison of mean scores of the experimental and control group on the age of the caregivers, length of stay with the patients and their family income. On Mann Whitney U test there was no significant difference was seen on any of the variables.

Table 3 indicates comparison on different domains of pre-post differences of family functioning assess between experimental and control group after a family intervention. In problem solving area pre-post mean differences were 5.00±3.31 and .40±.54 in experimental and control group respectively. After analysis significant difference was found in problem solving ability of family between both groups (z= -1.95, p≤0.05). In family communication area pre-post mean differences were 8.40±2.07 and .80±1.78 in experimental and control group respectively. After analysis most significant difference was found in family communication pattern between both groups (z= -2.70, p≤0.01). In the role functioning area pre-post mean differences were 4.80±2.58 and 1.20±2.16 in experimental group and control group respectively. After analysis significant difference was found in family members role functioning between both groups (z= -2.02, p≤0.05). In the family affective responsibility area pre-post mean differences were 3.80±3.49 and 1.40±3.71 in experimental and control group respectively. After analysis significant difference was not found in family affective responsibility between both groups (z= -.742, p≥0.05) bout had slightly difference. In the affective involvement area pre-post mean differences were 7.60±3.04 and 2.20±3.03 in experimental and control group respectively. After analysis significant difference was found in family members affective involvement between both groups (z= -2.12, p≤0.05). In the behavioural control area pre-post mean differences were 9.00±3.24 and 2.00±4.47 in experimental and control group respectively. After analysis significant difference was not found in family members behavioural control between both groups (z= -1.83, p≥0.05) bout slightly difference found. In the general functioning area pre-post mean differences were 6.60±3.20 and .80±2.38 in experimental and control group respectively. After analysis most significant difference was found in family members general functioning between both groups (z= -2.44, p≤0.01). In the Mc Master family assessment device pre-post mean differences were 45.20±6.01 and 8.80±15.50 in experimental and control group respectively. After analysis most significant difference was found in Mc Master family assessment device between both groups (z= -265, p≤0.01).

Table 3 indicates comparison of pre-post differences of coping in the persons with alcohol dependence syndrome experimental group and control group after strength based supportive family intervention. Persons with alcohol dependence syndrome coping pre-post mean differences were -30.80±8.92 and -8.80±13.42 in experimental group and control group respectively. After analysis significant difference was found in the coping between both group (z= -2.20, p≤0.05).

Follow up

To find out the durability of strength based supportive family intervention with persons with alcohol dependence syndrome; comparison between immediate after intervention and on follow up after three months was done on the scores of the Mc Master Family Assessment Device and Brief Cope Scale for the intervention group using Wilcoxon Sign Rank Test.

Table 4.1 shows the comparison of family functioning between post intervention and follow up on the intervention group. It shows that there were no significant differences in the score of the Mc Master Family Assessment Device in all domains and total family functioning. It means therapeutic outcome was maintained on follow up after three months.

Table 4.2 shows the comparison of persons of alcohol dependence syndrome on coping between post intervention and follow up scores of the intervention group. It shows there was no significant difference (no decline) in the post and follow up coping strategy of Persons with alcohol dependence syndrome. It means therapeutic outcome was maintained.

DISCUSSION

Results suggest that strength based supportive family intervention found to be effective which brought significant improvement in the family functioning i.e. in family problem solving, communication, role and functioning, affective responsibility, affective involvement, behavioural control and general functioning, as well as all over family functioning and improvement sustained on follow up assessment after 3 months.

Before the conjoint family intervention, persons with alcohol dependence had poor coping, after conjoint strength based supportive family intervention, a significant improvement on coping skills was seen and which was sustained on follow up assessment after 3 months also.

Table-4.1 Comparison of family Assessment between post intervention and on follow up of intervention group

Area of assessment	Experimental Group (Mean ± SD)		Wilcoxon Sign Test		
	Post	Follow up	Sign	Mean Rank	Z- Score
Problem Solving	10.40±1.51	11.40±2.19	+	2.50	
			-	5.00	
Communication	15.00±2.00	16.00±1.41	+	2.33	-.736 NS
			-	3.00	
Role	25.60±1.51	26.20±4.14	+	2.50	.00NS
			-	2.50	
Affective Responsibility	10.80±2.38	11.20±1.19	+	3.00	.00NS
			-	1.50	
Affective Involvement	11.60±1.67	14.20±2.04	+	2.50	-1.82NS
			-	.00	
Behavioural Control	14.20±2.86	15.40±1.51	+	2.83	-1.30NS
			-	1.50	
General Functioning	25.60±1.34	25.20±1.92	+	2.50	.000NS
			-	2.50	
Total	1.1320E±2.16	1.1960E±7.02	+	3.50	-1.75NS
			-	1.00	

NS= Not Significance, *=Significance at 0.05 & ** =Significance at 0.01

Table-4.2 Comparison on Coping, post intervention and on follow up of experimental group

Area of assessment	Experimental Group (Mean ± SD)		Wilcoxon Sign Rank Test		
	Post	Follow up	Sign	Mean Rank	Z-Score
Coping	94.80±3.34	92.00±4.94	+	.00	-1.60NS
			-	2.00	
			-	2.00	
			-	2.000	

NS= Not Significance

Present study findings are consistent with a study where treatment package extended to the subjects; the skill to maintain abstinence from alcohol to a greater extent compared to the restricted brief psychotherapy group. The study has demonstrated better outcome in terms of treatment compliance, subjects' ability to cope with drinking, marital stability and subjective well-being when individual alcoholism treatment was combined with marital or family therapy.[14] Present study findings are also consistent with other studies.[6,7]

A study finding consistent with our study in which has a meta-analysis of randomized controlled trials, study 113 articles from a database search. The results of this meta-analysis suggest family interventions be effective in reducing adolescent alcohol consumption, even at 48 months. However, only a small number of studies reported the effect of family interventions on alcohol consumption of adolescents, in general populations. Moreover, just three studies reported the long-term effect of the intervention and that family intervention are likely to be effective in delaying the age of alcohol initiation and in control and limited drinking behaviours in young persons.[15]

The study found that alcoholics have extensive marital and family problems, and hence positive marital and family adjustment is associated with better outcome. It has been reported that even at the onset of recovery from alcohol dependence, marital and family conflicts and strain may often precipitate and lead to relapses in abstinent alcoholics.[16]

In our study, it was found that before giving strength based supportive therapy family interventions persons with alcohol dependence syndrome faces problem in coping skill the adverse conditions and used to be subdued under the pressure of stress in little bit of time but with conjoint family intervention patient coping style increased and it was sustained in follow up. Our findings consistent with this study for the family intervention in the form of motivating the patient to seek treatment, educating family members and partner about the condition, teaching coping skills and achieving abstinence and maintaining it. It also helps improve the areas of functioning and interpersonal relations.[17] The present study finding are also consistent with the finding of a study which found that only by improving the coping skill and tackling interpersonal environmental factors and intra factors such as stimulus control, confrontation with negative emotions, confrontation with failure and anger, interpersonal conflicts (new and previous conflicts with friends, member of the family and attendants), identifying risky situation, in general, are specific coping strategy from which person would obtain necessary cognition, behaviour, emotional abilities to confront with relapse.[10]

LIMITATIONS

1. The sample size was small which limits the generalization of the finding
2. Since it was a time bound study hence only male Samples were selected for the study due to availability.
3. The study was a hospital based and included only persons with alcohol dependence, so the results of the study cannot be generalized in other substance dependent sample.

CONCLUSION

As the strength based supportive conjoint family therapy used to bring both caregivers and persons with alcohol dependence syndrome on a common platform, they faced each other and misunderstanding in terms of poor communication, role confusion, sharing of responsibilities, problem solving ability which were improved along with family functioning and environment. Also simultaneously improvement was seen in coping strategy of the persons with alcohol dependence syndrome; as a consequence re-hospitalization and relapse of individual were reduces and they stopped taking alcohol which improves their family environment.

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