

Psychosocial Challenges Faced by Family Caregivers of Patients with Substance Use Disorders at a Local Hospital in Harare, Zimbabwe

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Abstract

This study examined the psychological challenges faced by family caregivers of substance use disorder (SUD) patients with cases drawn from Sally Mugabe Hospital in Zimbabwe. Objectives included describing caregivers' duties, assessing their psychological challenges, and identifying coping mechanisms using a qualitative approach. Purposive random sampling was administered to draw up a sample and data saturation was used to determine the sample size of ten participants. Thematic analysis produced three main themes, which resulted in various subthemes, respectively. Key findings showed that caregivers manage medication, finances, daily tasks, crises, and medical appointments, while experiencing significant issues like anxiety, depression and burnout. To cope, they engaged in support groups, religious practices and sought professional help. The study concluded that family caregivers often endure substantial psychological distress and thereby recommend comprehensive training on SUD management, access to mental health professionals for therapy and mentorship between new and experienced caregiver support.

Keywords: Anxiety, caregiver, stress, substance use disorder

Introduction

Hernandez et al. (2022) define substance use disorder (SUD) as a mental health condition characterised by a problematic pattern of substance use that causes distress or impairs an individual's life. Selotole, Temane and Poggenpoel (2022) note that many individuals diagnosed with SUD live in close contact with informal caregivers, often close relatives such as parents, siblings, or children, who find managing the situation very difficult. Hlungwani et al. (2020) note that people abusing substances may exhibit unpredictable behaviour and frequently experience physical and emotional problems, including depression and aggression. Selotole, Temane and Poggenpoel (2022) note that substances can cause intoxication and alter an individual's judgment and perception. Tylor (2018) asserts that SUD patients are often irritable and aggressive towards their caregivers, who in turn may feel hopeless, frustrated, and helpless when the patient relapses under their care. Selotole, Temane and Poggenpoel (2022) posit that SUD can lead to various

psychosocial problems, such as decreased quality of life, for both the affected individual and their family members.

Selotole, Temane and Poggenpoel (2022) note that a study conducted in the United States in the eighties discovered that between one-third and two-thirds of persons with substance induced psychosis disorder (SIPD) were cared for by their family members in their respective homes. They further note that a comparative study from China also determined that more than 50% of SIPD patients lived with their relatives, and that they were unmanageable. Another United Kingdom study conducted in the eighties confirmed that psychotic disorders such as schizophrenia, SIPD and bipolar mood disorder were severe and disabling mental health conditions that affected several million people worldwide. Most caregivers are family members and being a caregiver is a selfless role that involves prioritising someone else's needs, sacrificing time and peace of mind, and cultivating patience and understanding. Maina et al. (2021) note that caring for an individual with addiction creates persistent stressful circumstances, which can cause worry, anger, depression, shame, guilt, anxiety, and behavioural problems within the family. Maina et al. (2021) further indicate that the stress associated with caring for a family member with an addiction can cause psychiatric disorders such as anxiety and depression, interpersonal problems, children's behavioural problems, and low self-esteem. Peltzer et al. (2010) note that South Africa is a major market for illicit drugs in sub-Saharan Africa, with increased substance abuse noted since 1994. *Nyaope*, a relatively new psychoactive drug cocktail, has become prevalent in the South African drug market. Cannabis remains the most widely used illicit substance in the African region. West and Central Africa report the highest prevalence and increase in cannabis use, with rates between 5.2% and 13.5%. Ghanaian Health Statistics from 2014–2018 indicated that 35% of Ghanaian households had at least one person with SUD cared for by relatives at home. This has led to an increased number of people being diagnosed with SUD.

In Zimbabwe, reports indicate an escalating prevalence of substance use. Over half of individuals admitted to inpatient mental health units are reportedly experiencing a substance-induced disorder. Drug and substance abuse continue to rise in Zimbabwe, particularly in urban areas and especially among young people. According to the Ministry of Health and Childcare, commonly abused drugs in Zimbabwe include codeine; methamphetamine (crystal meth, commonly known as meth, speed, *mutoriro*, chalk, ice, crank, *guka*); glue; broncleer (also known as bronco); solvents – *fembo* and

genkem; clorpromazine – mragado; *mangemba*; cane spirit; cocaine, cannabis/ marijuana/ mbanje (which is mostly abused or traded under a variety of street names such as - mbanje, ganja, dope, weed, blunt, grass, pot, boom, spliff, Mary-jane, skunk, kiff).

Family caregivers of individuals with substance use disorder (SUD) undertake a multifaceted role encompassing emotional support, clinical supervision, and financial stewardship, yet this high-stakes advocacy often precipitates a profound psychological crisis characterised by systemic depletion. Beyond facilitating a non-judgmental therapeutic environment and managing complex medication regimens and cognitive-financial impairments, caregivers frequently succumb to the deleterious effects of chronic vigilance, leading to compassion fatigue, social sequestration, and "silent" health deterioration (McCann & Lubman, 2018). This emotional journey is further complicated by internalised stigma, pervasive guilt regarding the etiology of addiction, and untreated depressive symptoms stemming from a diminished sense of self (Marcon et al., 2012). To mitigate these risks, a robust framework of coping mechanisms is essential, shifting from a model of self-sacrifice toward one of sustainability through evidence-based interventions such as cognitive-behavioural therapy, structured support networks, and intermittent respite care, which collectively foster resilience and preserve the caregiver's longitudinal capacity for effective care (Strong & Busch, 2013).

The transactional model of stress and coping, developed by Lazarus and Folkman in 1984, is a psychological framework that examines how individuals perceive and respond to stressors in their environment. This study is grounded in Lazarus and Folkman's stress and coping theory because its tenets resonate with how family caregivers of patients with substance use disorders experience and manage psychological challenges. Miodrag and Hodapp (2011) note that the model identifies two coping styles which are problem focused coping and emotion focused coping. This dual framework clearly outlines the dynamic ways in which the family caregivers respond to stress.

Research design

This study employed a qualitative approach to investigate the psychological challenges experienced by family caregivers of individuals with SUD. The aim of the study was to understand caregivers' lived experiences, meanings and coping processes and not to measure how common those experiences were. The qualitative approach helped the researcher to explore how psychological challenges were understood and experienced by the caregivers. Open-ended

qualitative data enabled the exploration of multiple facets of caregivers' psychological challenges such as emotions, triggers, effects of daily life and coping strategies.

Study setting and population

The research was conducted at the Sally Mugabe Psychiatric Hospital in Harare. This site was selected due to its high volume of both inpatient and outpatient SUD clients. The target population comprised informal caregivers accompanying SUD patients to the hospital's psychiatric unit. The study had predetermined inclusion and exclusion criteria that assisted in identifying the population from which a sample was drawn. The participants had to be caregivers of the hospital's SUD patients for a period of six months and above and were willing to share their psychological experiences. Another inclusion criterion was that the caregivers were supposed to be eighteen years of age and above. The exclusion criterion was that the research was not going to engage caregivers who were too distressed and not able participate in the study.

Sampling procedure

Purposive sampling was used and a total of ten participants were selected based on the predefined inclusion criteria. Initially the research had targeted 20 participants for the study sample, but it was through data saturation that a sample of 10 participants was considered. The research employed a purposive random sampling to draw a sample through randomly engaging caregivers who had accompanied SUD patients to the hospital. The purposive random sampling produced a trend from which this study assumed most of the caregivers for SUD patients were females because of the gender distribution of the participants. This sampling strategy ensured a diverse demographic representation, allowing for an in-depth understanding of the specific characteristics pertinent to the research objectives.

Data Collection

Primary data were gathered via a semi-structured questionnaire designed to address sociodemographic profiles, caregiving responsibilities, psychological challenges, and coping strategies. The instrument utilised a blend of closed-ended and open-ended questions, ensuring respondent anonymity while providing the flexibility to capture qualitative insights that quantitative metrics could have overlooked.

Data analysis

The study employed thematic analysis to interpret the qualitative responses. This method identified recurring themes and patterns, providing a narrative framework to explain the underlying causes of caregiver stress and the complexities of their coping strategies in relation to the primary research questions. During the research the thematic analysis helped to identify major themes, namely duties of caregivers, psychological challenges and the coping mechanisms. The study managed to identify sub-themes for duties of caregivers, and these are medication management, financial stewardship, clinical adherence and crises management. Anxiety, depression, burnout, stigma, shame, sleep difficulties and trauma are some of the sub-themes that emerged from the psychological challenges. The sub-themes for coping mechanisms are support groups, religion, respite care, training and taking breaks.

Ethical considerations

Prior to data collection, approval was obtained from the Sally Mugabe Central Ethics Committee and the participants received details of the study before providing consent. To maintain confidentiality, no personal identifiers were recorded, electronic files were secured with passwords and hard copies kept under key and lock. Participation was voluntary, with the right to withdraw at any stage without prejudice. Given the sensitivity of the study, the participants' mental health was a primary concern in this research.

Results

The table below shows the socio-demographic details of the family caregivers.

Table 1: The socio-demographic details of the family caregivers

Participant	Gender	Age	Period of caring	Relationship with patient	Employment status
Participant 1	Female	40	9 months	Sister	Employed
Participant 2	Female	45	3 years	Mother	Employed
Participant 3	Male	59	2 years	Grandfather	Unemployed
Participant 4	Female	20	4 months	Daughter	Student
Participant 5	Male	37	3 years	Brother	Employed
Participant 6	Male	55	5 years	Father	Retired
Participant 7	Female	60	6 years	Mother	Retired
Participant 8	Female	62	4 years	Grandmother	Retired
Participant 9	Female	51	10 months	Mother	Unemployed
Participant 10	Male	48	2 years	Father	Employed

The demographic profile of caregivers for individuals with substance use disorder (SUD) reveals a predominantly female cohort, indicating a gendered disproportion in the assumption of informal

caregiving responsibilities. Spanning a broad developmental spectrum from young adulthood to late maturity (20–62 years), the sample is characterised by a high concentration of middle-aged and older adults - including retired individuals who provide long-term support ranging from several months to six years. These caregivers are primarily immediate or extended kin, such as parents, siblings, and grandparents, who must navigate diverse employment statuses - including full-time work, unemployment, and academic pursuits - while maintaining their commitment to the patient's recovery.

Duties of caregivers

Effective medication management is a critical caregiver responsibility, requiring strict adherence to prescribed dosages and schedules to prevent treatment defaults or accidental overdoses. Consistent with findings by Sher and Verges (2016), this study highlights that accurate administration is predicated on robust, tripartite communication between clinicians, patients, and caregivers to ensure procedural safety and therapeutic compliance.

One of the duties of being a caregiver is to make sure that my son takes his medication three times a day. Sometimes, my son usually forgets to take their medication and there was a time when he overdosed his medication.

Caregivers function as essential financial stewards for patients, mitigating the economic burden of substance use disorder (SUD) by covering medical expenses, funding clinical appointments, and providing strategic financial guidance. This research indicates that, while such support is vital for patient stability, it frequently induces significant caregiver strain, potentially compromising the caregivers' own longitudinal financial security.

Managing my mother's finances is difficult because when she is drunk, she tends to make poor financial decisions like overspending. In trying to avoid mismanagement of finances, it is crucial to buy her medication and pay for doctor's appointments first, since three quarters of her salary is directed towards her medical expenses.

Caregivers serve as critical conduits for clinical adherence by facilitating patient attendance at medical consultations and therapeutic sessions. This supportive role is particularly vital for patients experiencing cognitive deficits or incomplete recovery, necessitating consistent reminders and physical accompaniment to ensure engagement with the treatment plan. Consistent with Ayres (2008), these findings indicate that caregiver presence extends beyond simple logistics to active

participation in the clinical process, providing practitioners with essential longitudinal insights into patient progress and barriers to recovery.

These days my phone sends notification reminders of dates for my brother's doctors' appointment as he usually forgets and misses them.

Beyond clinical and financial management, family caregivers perform essential instrumental activities of daily living (IADLs), addressing the self-care deficits frequently associated with substance use disorder (SUD). As corroborated by Rosland, Heisler, and Piette (2012), this laborious duty encompasses the maintenance of personal hygiene, nutritional support, and environmental sanitation. The study's findings indicate that pervasive patient neglect of personal and domestic hygiene creates a significant state of functional dependency, necessitating sustained caregiver intervention to ensure basic health and living standards. Caregivers shared how they assisted with daily tasks and highlighted this:

Helping with daily tasks like personal hygiene and household chores is the duty of a family caregiver because the patients sometimes refuse to take a bath or to even change their clothes.

Most caregivers reported handling crises, such as patient relapses, by facilitating hospital readmissions for ongoing treatment and withdrawal management. The study found that this responsibility is often stressful and emotionally draining for caregivers, highlighting the need for support in crisis management. One caregiver narrated:

It is the responsibility of a caregiver to get the patient readmitted at the hospital after the occurrence of a relapse and manage the withdrawal symptoms.

Most caregivers reported not receiving training for caring for patients with substance use disorders (SUD) due to factors such as a lack of awareness, fear of stigma, and overwhelming responsibilities. This lack of training can negatively impact patients' recovery. While some family caregivers did receive training, Soraya (2022) emphasises the importance of implementing policies, educational programmes, and awareness campaigns to address the psychological challenges faced by caregivers. One caregiver shared the reason they did not receive any training:

Taking care of my uncle is difficult, especially for us ordinary citizens without formal training due to a lack of awareness and proper training. At times it's quite overwhelming having to apply general knowledge to aspects that need professional expertise. At one

time when I accompanied my uncle for a session, the doctor conducted a brief training session, and it was quite beneficial and informative as a caregiver.

Many caregivers do not receive training for caring for substance use disorder (SUD) patients due to a lack of awareness, stigma, and overwhelming responsibilities, which can hinder patient recovery. Some caregivers had received training, highlighting the need for policies and programmes to support caregivers' psychological challenges, as emphasised by Soraya (2022). The study established that caregivers had different views as they expressed how they found balance between personal life and caregiving as illustrated by some of their responses:

It is hard to balance caregiving and my personal life. Social and work life has been affected a lot to the extent of even missing work.

Taking breaks and delegating caregiving duties to other family members helps to balance caregiving and personal life.

Psychological challenges

i) Anxiety

The study revealed that anxiety was one of the psychological challenges encountered by family caregivers. According to Tyler (2018), caregivers constantly worry about the individual's wellbeing, safety and potential relapse leading to increased anxiety levels. The findings from the study revealed that most caregivers worried about the patient's condition and future. Unmanaged anxiety can negatively impact caregivers' physical and emotional wellbeing. Caregivers require access to support systems to manage anxiety. One caregiver said:

Giving birth is a painful experience and having to worry about my son's condition and future is a feeling that takes away all the happiness in the world. It causes emotional distress daily.

ii) Caregiver burnout

Family caregivers reported that the other challenge they faced was burnout. Caregiver burnout occurs when a caregiver completely neglects their own needs which makes them more physically and emotionally exhausted and fails to care for themselves. The findings are supported by McMonn and Lubman (2018) who argued that caregivers neglect their own needs including socialising, self-care and pursuing personal interests. Findings from the study revealed that burnout can impact caregivers' physical and emotional wellbeing. One caregiver described the effects of burnout they experienced:

Caregiving disrupts the social and personal life including spending time and socialising with family and friends, self-care and pursuing personal interests due to exhaustion.”

ii) Depression

This research established that most family caregivers attested to depression as another psychological challenge they were facing. Depression causes caregivers to feel sad, lose hope and interest in activities they previously enjoyed. Hlungwani et al. (2020), as quoted by Selotole, Temane and Poggenpoel (2022), note that the constant demands coupled with feelings of hopelessness and a lack of support can lead to a depressive state. Findings from the study revealed that caregivers were stressed by the condition of their patients and some had even lost hope of providing quality care for the patient. Stress was affecting their overall wellbeing and physical health and this reduced their ability to provide quality care. Caregivers shared that:

It is stressful taking care of my brother, especially when the situation is not getting better. There is no peace of mind when dealing with a situation like this one and, especially when you are carrying out the burden alone as other family members have disassociated themselves from my brother. Being judged as a parent by society when caring for a child with SUD is painful. It is depressing to listen to people’s criticism.

iii) Stigma and shame

Caregivers reported being ostracised and isolated by the community. They expressed that there was a lot of stigmas associated with mental illness, which they attributed to a lack of knowledge by relatives and the community at large. The findings are supported by Doherty (2019) who states that caregivers may feel stigmatised and ashamed about their loved one’s addiction, leading to withdrawal and decreased support seeking. Stigma can worsen caregiver burden, which impacts their overall wellbeing. Findings from the study showed that educating the community about mental illness can reduce stigma and provide a supportive environment for caregivers and patients. Some of the family caregivers narrated:

Community members no longer feel safe and comfortable walking in the streets or visiting our home as they resent my father. Some people in society have even started addressing my father as a madman, which is unfair and insulting because at the end of the day a human being deserves respect and empathy regardless of his behaviour.

iv) Sleep difficulties

Caregivers reported that they struggled with sleeping difficulties because of caregiving. This is because of general worry for the patient and coping with the patients’ irregular circadian rhythm. According to Doherty (2019), sleep deprivation can be a major problem because it affects the caregiver’s physical and emotional wellbeing. The study reveals that family caregivers fail to sleep

due to constant worry about the patient's condition and the occurrence of a relapse. The other reason for sleep difficulties could be attributed to exhaustion because caring for a SUD patient could be cumbersome, and may require the caregiver to be awake during odd hours. Some caregivers expressed that they were disturbed by the patient. Caregivers shared that:

Some of the medication prescribed by the doctors causes my brother to have trouble with sleep, hence when he is not asleep, he disturbs everyone from having a good night sleep after a tiresome day. The constant worry of the thought of him relapsing again is a thought that also causes sleepless nights for caregivers, especially when his friends start reaching out to him knowing very well that some of them were the root cause of the problem being faced currently.

v) Trauma

The study revealed that caregivers experienced trauma because of caregiving. Caregivers experience trauma because of the violent and aggressive behaviours presented by the patients. It causes caregivers to live in constant fear and experience flashbacks. The trauma experienced by caregivers affects their wellbeing and ability to provide care. Findings from the study highlighted that the safety and wellbeing of the caregivers should be prioritised, measures should be put in place to minimise exposure to violent behaviours. One participant said:

It is never easy to take care of a violent patient because of the risk of facing emotional and physical harm which can be traumatic for the caregiver.

Coping mechanisms for family caregivers

i) Support groups

Caregivers attested that support from friends, family and the community helps with emotional support, cope with stress, and deal with feelings of isolation. Support groups can be church members or caregivers in a similar situation. According to Walke et al. (2018), support groups and counselling can offer emotional support and practical advice from others who understand the challenges of caregiving. Findings from the study revealed that most of the caregivers were assisted by their neighbours and family members. It shows the importance of support networks in caring for patients. Caregivers expressed the support they received, and one said that:

Neighbours and family members are a strong support network when faced with worst encounters including relapses and violence from the patient.

ii) Religion

Caregivers shared that prayers provided them with a sense of hope that helps them cope with the burden of caregiving. The finding is supported by Rahman (2019) who argued that prayer seems

to provide a sense of hope for caregivers that sort of help them cope with the burden. The study revealed that caregivers used religion as a coping mechanism as it gave them strength and hope in times of challenges. Caregivers shared:

Religion helps caregivers cope through the power of prayers and believing in God.

iii) Taking breaks

Family caregivers attested that taking breaks can be a good coping mechanism. Taking breaks allows caregivers to rest and recharge. The study revealed that caregivers can have time to focus on their personal, social and academic lives. Caregivers can delegate responsibilities to other family members. Regular breaks can help caregivers sustain their caregiving role over time and reduce the risk of burnout and stress. Some of caregivers expressed:

Taking care of my mother is taking most of my study time, hence taking a break gives a chance to focus on studies and catch up with the others at school.

Another caregiver shared:

Sometimes my brother and other family members help with caregiving responsibilities.

iv) Respite care

Caregivers reported that admitting patients at rehabilitation centres can help them have a sense of temporary relief from care giving responsibilities. Caregivers are allowed to rest and recharge. The findings are supported by Hogan and Langba (2015) who note that offering caregivers periodic respite contributes to their overall wellbeing and helps prevent burnout. Some of the caregivers expressed that:

The government can build rehabilitation centres for patients where they can stay and be taught life orientation skills and handicrafts.

Another caregiver shared their view on the need for respite care:

If possible, the patient can stay in rehabilitation centres because we have failed.

v) Professional help

Caregivers reported that another coping strategy would be seeking professional help from therapists and counsellors. Mental health professionals help caregivers with coping strategies, enhancing wellbeing and reducing stress. According to Strong and Busch (2013), family therapy can be done as a coping mechanism between the family caregivers and patients. Findings from the

study revealed that most caregivers rarely sought help from therapists because they thought they could handle the burden on their own.

vi) Training and education

Caregivers revealed that they required training to deal with psychological problems. Most caregivers expressed a lack of knowledge about the condition their relatives suffered from because it was never explained to them. Doctors need to explain more about the condition of the patient. The findings revealed the importance of training and education as a recommendation to cope with challenges. One caregiver shared that:

Usually the doctor's appointments time would be so limited to the extent that it's impossible to ask questions or comprehend every detail being explained. If only sessions could be extended so that caregivers could have ample time to ask questions about their relative's medical condition.

Discussion

This study explored the sociodemographic characteristics of family caregivers for patients with substance use disorders (SUD), focusing on the psychological challenges they encounter, and the coping mechanisms employed. Findings indicated a diverse age distribution among caregivers, with a significant proportion aged 40-65, suggesting that they navigated caregiving alongside career and family responsibilities. Gender analysis revealed that 60% of caregivers were female, which reflects traditional gender roles, though 40% male participation indicates a growing involvement of men. Employment status varied, with 40% of caregivers employed, and the duration of caregiving also varied, implying a long-term commitment among many. Responsibilities undertaken by caregivers included medication and financial management, crisis handling, and daily assistance, all contributing to a notable caregiver burden.

The study also uncovered various psychological challenges faced by family caregivers, including anxiety, depression, and burnout, which adversely affect both the caregiver's well-being and the quality of patient care. A significant 80% reported lacking training in caregiving for SUD patients, a gap attributed to stigma and inadequate awareness. While 70% acknowledged the importance of their role in mitigating relapse rates, many experienced frustrations and sought support from family and friends. Coping strategies varied; with some caregivers taking breaks, seeking professional help, and participating in support groups. The emotional complexities of caring for relatives were evident, with 60% finding it more challenging due to attachment issues. These

findings emphasise the urgent need for educational programmes and structured support to improve the caregiving experience and overall outcomes for both caregivers and patients.

Conclusion

This study provided valuable insights into the multifaceted experiences of family caregivers for individuals with SUD, specifically detailing their duties, the psychological challenges they encounter, and their coping mechanisms. The research revealed that family caregivers manage a wide array of responsibilities, including crisis intervention, medication administration, financial oversight, accompanying patients to medical appointments, and assisting with daily living tasks. These extensive duties underscore a critical need for enhanced caregiver education, specialised training, and the establishment of robust support systems and resources. This is particularly vital given that prevailing issues such as a lack of awareness, restrictive cultural norms, stigma, and shame, which frequently impede caregivers' access to necessary help and treatment. Furthermore, the study unequivocally demonstrated that caregivers face significant psychological burdens, manifesting as depression, anxiety, trauma, sleeping difficulties, and caregiver burnout. These findings highlight the urgent need for targeted training programmes designed to equip caregivers with the skills to effectively manage the complex demands of caring for SUD patients. Finally, the study identified several crucial coping mechanisms employed by caregivers, including participation in support groups, seeking further education, utilising respite care, and accessing professional psychological help. This necessitates a proactive role for mental health facilities in providing comprehensive support. Interventions such as group therapy, family home visits, and specialised family therapy are essential to empower caregivers to develop healthy coping strategies and navigate their challenging experiences more effectively.

Recommendations

Duties of family caregivers living with a substance use disorder patients

- There is a need for comprehensive training for caregivers focusing on SUD management, coping strategies, and the psychological aspects of caregiving.
- Regular workshops and webinars should be facilitated regularly to offer hands-on skills, emotional support techniques, and information about available resources.

Psychological challenges faced by family caregivers living with SUD patients

- There is a need to ensure that caregivers have easy access to mental health professionals for individual or group therapy focused on coping with caregiver burden.
- Launch campaigns aimed at reducing the stigma around SUD and caregiving, promoting understanding and acceptance within the community.
- There is a need for longitudinal studies to monitor the long-term effects of caregiving on mental health and well-being. Longitudinal studies will create an opportunity to explore the experiences of a broader range of caregivers, including those from different cultural backgrounds and socioeconomic statuses, to identify unique challenges and needs.

Coping mechanisms for family caregivers living with SUD patients

- There is a need for peer mentoring where new caregivers are paired with experienced ones for the former to have guidance and emotional support.
- There should be policies that recognise the contributions of family caregivers and provide them with financial support, training and health benefits.
- Promote telehealth options for mental health support, allowing caregivers to access help conveniently.

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