

The Effectiveness of Family Empowerment on Psychological Disturbance and Emotional Expression in Adolescents with Substance Dependent Parents

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Abstract

Objective: The present study aimed to determine the effectiveness of family empowerment with social-emotional learning on psychological disturbance and emotional expression in adolescents with substance abuse parents.

Method: The research method was semi-experimental with a pre-test-post-test design and a control and follow-up group. The statistical population consisted of teenagers with substance-dependent parents in Tabriz who had been referred to drug addiction treatment centers in Tabriz in the fall of 2021. Thirty people were purposefully selected and were randomly assigned into two experimental and control groups. Research data were collected using the depression, anxiety, and stress scale (DASS-21) by Lovibond and Lovibond (1995) and the emotional expression questionnaire (EEQ) by King and Emmons (1990) and were analyzed by variance analysis with repeated measurements.

Results: The results of the present study showed that family empowerment affects the emotional expression, depression, anxiety, and stress of adolescents with substance-dependent parents ($P < 0.01$), and this effect was stable in the three-month follow-up ($P < 0.01$).

Conclusion: According to the results, it can be concluded that empowering the family with a social-emotional learning program is one of the effective treatments for adolescents' psychological disturbance and emotional expression

Keywords: Emotional Expression, Family Empowerment, Psychological disturbance, Substance Abuse .

Introduction

Adolescence and the early years of youth are the peak period of prevalence and occurrence of most mental disorders. So mental disorders usually start in childhood and adolescence and continue until adulthood (Yuvaraj, Kumar, Priyan, et al. 2019). Also, one out of every eight children and adolescents has mental disorders

that lead to symptoms and deficiencies (Barican, Yung, Schwartz, et al., 2022). Epidemiological studies also show the overall prevalence of all childhood and adolescent mental disorders in high-income countries as 12.7%, and the global prevalence of common adolescent mental disorders, such as depression and anxiety, has been reported at 25 to 31% (Silva, Silva, Ronca, et al., 2020). Also, research shows that the role of parents and especially the head of the family has an impact on the destructive problems of children, such as disobedience and violation of the law (Doran et al., 2012).

A summary of several studies conducted on the children of parents who use drugs and alcohol shows that the lives of these families are associated with a lot of disturbance, stress, turmoil, and more psychological

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and social problems in their families (Morales, Vallejo-Medina, et al., 2018). As mentioned, mental disorders often occur in adolescence (Giedd et al., 2008). These disorders can have a wide range of chief side effects on the quality of life, relationships with family and friends, academic achievement, and future economic stability of adolescents and young adults (Rickwood Webb, Kennedy & Telford, 2016).

Adolescence provides countless developmental opportunities for adolescents who either engage in behaviors that lead to a healthy lifestyle or endanger their health. This is more pronounced in adolescents with addicted parents and puts them at risk for maladaptive and high-risk behaviors. Aulmann and Forstmeier (2019) and Raitasalo and Holmila (2017) emphasize that parental substance abuse can cause a variety of harm to children and adolescents. School-age children who live with drug-using parents suffer various emotional, cognitive, behavioral, and social problems (Hardy, 2017; Vilela, Silva, Grandi, et al., 2016; Narimani et al., 2014). In addition, alcohol and parental abuse can significantly increase the rate of behavioral disorders in children (Jose & Cherayi, 2020).

On the other hand, evidence based on research in psychology and neuroscience confirms the effect of emotions on the occurrence of high-risk behaviors and distress, and psychological disturbance (Heilman et al., 2016; Atadokht & Majdy, 2017). Several studies have shown a significant association between negative emotions such as anxiety and depression and the occurrence of high-risk behaviors (Kusev, Purser, Heilman, et al., 2017). Emotional expression, as one of the main components of emotion, refers to the external display of emotion, regardless of its value (positive or negative) or the way it is manifested as good and bad (facial, verbal, physical, or behavioral) (Hasani & Bemani Yazdi, 2015).

King and Emmons (1990) have introduced three basic dimensions of emotional expression: positive emotion expression, negative emotion expression, and intimacy expression. In this regard, studies that

examined the emotional components of addictive disorders have shown that there is a significant negative relationship between emotional expression styles and students' addiction tendencies (Esmail Beigi Mahani et al. 2019). Rahgozar, Akrami, and Mehrabi (2015) also showed that substance abusers have different emotional responses than normal individuals in expressed emotion. Sadri Damirchi, Navidi, and Pourshaneh (2017) found that among the components of emotional expression, negative emotion expression has a significant positive relationship with high-risk behaviors of addicts. Many methods have been developed and used to treat and empower the family, some of which have received empirical approval. However, psychological therapies are evolving and no single treatment can meet the needs of all individuals and families. Therefore, the findings of further research on achieving efficient treatments can reduce treatment costs with greater potential effectiveness. Among these, family-oriented therapies are of special importance due to their protective and dangerous role in family disturbance.

Family-centered therapies and rehabilitations are also evidence-based and empirically validated therapies. In addition, empowering the family with a social-emotional learning program (SEL) with an emphasis on teaching social-emotional skills development can be used as one of the most comprehensive and practical approaches. This approach is based on many factors that cause high-risk and problem-solving behaviors. The most prominent feature of this approach, compared to the social influence approach, is training self-management skills and social skills based on Bandura's cognitive-social theory (1986) and Jessor's theory of problem-solving behavior. This approach includes increasing decision-making power, changing personal behavior, wishing anxiety, increasing social assertiveness skills, communication, and applying general skills to deal with social pressures practiced through social-emotional learning training. Gunny Cooper Research Associates (2013, quoted in Dehghani & Mesrabadi, 2018) states that social

and emotional learning, in a very comprehensive definition, includes the process of acquiring and effectively using the necessary knowledge and skills to identify and manage emotions, developing care and communication with others, responsible decision-making, creating positive relationships, and creating positive relationships and developing basic social and emotional abilities in the individual.

This association also considers the components of social and emotional skills to include self-awareness, self-management, social awareness, relationship management, and responsible decision-making. Social and emotional learning is based on the application of cognitive and behavioral methods and techniques, which focus on the learner's self-control, social competence, empathy, self-motivation, and self-control. It is also known as a way to reduce behavioral problems and promote individual factors. In the short run, this learning increases social and cognitive competencies and reduces aggressive behaviors, and in the long run, it increases emotional perception and self-control and decreases impulsive behaviors. Most psychologists believe that responding effectively to everyday life stresses requires the acquisition of emotional awareness, responsible decision-making skills, and successful social interactions. Socio-emotional learning relies on teaching self-control techniques, social competence, indoctrination, motivation, and self-efficacy in individuals. Research findings have shown that these techniques have been effective in reducing behavioral problems and replacing negative thoughts with positive ones (Dehghani & Misrabadi, 2018).

Regarding the effectiveness of socio-emotional learning on the psychological variables, Cejudo, Losada, and Feltrero (2020) showed that social-emotional learning leads to improvement in mental health, positive affect, and quality of life. Ratcliffe et al. (2014) showed that teaching social-emotional skills leads to improvement in the mental and emotional health of children with autism. Mokarram, Kazemi, and Taklavi (2021) showed that teaching socio-emotional

skills increases adolescents' social competence. The results of Golrokh and Naemi (2016) also indicate that teaching social-emotional skills lead to the increased psychological well-being of female students. Hosseini et al (2019) also showed teaching social-emotional skills has a positive effect on student's mental well-being and their academic adjustment. Mahdianfar, Kimiaei, and Ghorbani Hashem Abadi (2015) also found that psychosocial empowerment reduced depression and aggression.

In addition, adolescence is the peak period of the prevalence and incidence of psychological problems (Rickwood et al., 2016). The summary of several studies conducted on the children of parents addicted to alcohol and drugs also showed that the lives of these families are associated with a lot of disturbance, stress and turmoil, and psychological problems (Morales et al., 2018). Also, compared to their peers, children of parents with substance abuse have higher rates of anxiety, depression, opposition, behavioral problems, aggressive behaviors, and lower levels of self-esteem and social competence (Okasha, Ibrahim, Naguib, et al.2021; Delaney, 2020; Solis, Shodur, Burns & Hussong, 2012). In addition, emotional expression was directly related to psychological disturbance (Basharpour, Alimoradani Soomeh & Shah Mohammadzadeh, 2014), and parents' emotional expression is associated with emotional and behavioral problems of their children (Ahadi, Hejazi & Behpajhooh, 2004). These indicate the need to investigate the psychological disturbance and adolescents' emotional expression with parents with substance abuse in psychotherapy studies. Therefore, due to the above-mentioned and the lack of studies on the effectiveness of family empowerment based on social-emotional learning on psychological disturbance and emotional expression of adolescents with addicted parents, this study aimed to determine the effectiveness of family empowerment based on social learning.

Method

The present study method was semi-experimental

with a pre-test-post-test design and a control group and follow-up. The statistical population of the present study was adolescent boys with parents suffering from substance abuse who had been referred to drug addiction treatment centers in Tabriz in the fall of 2021 to get rid of their addiction to methadone. For sampling, first, by using a targeted sampling method, the people suffering from substance abuse who are being treated, 30-60 years old, who lived with their spouse and family, and who had a teenage son, were identified among the adolescents. They selected 30 people and randomly assigned them to two groups of 15 people, experimental and control, and entered the research together with their parents. The inclusion criteria were informed consent for participating in the study, having parents with drug abuse, age 14 to 19 years, and living with parents and family. Exclusion criteria included acute or chronic mental disorder, failure to participate in family empowerment sessions for two sessions or more, and distortion of answer sheets.

Ethical statement

Regarding ethical considerations, the present study has been approved by the research committee of Mohaghegh Ardabili University. Also, informed consent was obtained from all the research participants to participate in the research, and the subjects were free to leave the study at any stage. Finally, the control group could be subjected to intervention with the rehabilitation program used in the research after research if they wished.

Measures

The following tools were used to measure the dependent variables of the research.

Demographic questionnaire: It included demographic data including age, education, employment status, family income, socioeconomic status, father's current employment status, father's job, period of father's treatment, and the number of family members.

Emotional Expression Questionnaire (EEQ): The Emotional Expression Questionnaire was designed

by King and Emmons (1990) to examine the role of emotional expression in health. The questionnaire consists of 16 items and three sub-components; items 1 to 7 express positive emotions, items 8 to 12 express intimacy, and items 13 to 16 evaluate the sub-components of negative emotion. The response to this tool takes place on a 5-point Likert scale from strongly agree =1 to strongly disagree =5. The scoring of Items 7, 8, and 9 is reversed. King and Emmons (1990) evaluated its construct and convergent validity. The factor analysis result confirmed three factors: positive emotion expression, intimacy expression, and negative emotion expression. Regarding the convergent validity, a significant positive correlation was found between the scores of the Emotional Expression Questionnaire and the Multidimensional Personality Questionnaire ($r = 0.27$), and the Bradburn Positive Emotion Scale ($r = 0.24$). King and Emmons (1990) examined its internal consistency using Cronbach's alpha coefficient for the whole questionnaire and its subcomponents, 0.70, 0.74, 0.63, and 0.67, respectively. In the Persian version, the validity of this instrument was examined using internal consistency and Cronbach's alpha coefficient for the whole questionnaire, and the subcomponents of positive emotion, intimacy, and negative emotion were 0.71, 0.68, 0.65, and 0.68, respectively (Hasani & Shahgholian, 2014). In the present study, Cronbach's alpha for each of the components of positive emotion expression, intimacy expression, and negative emotion expression was 0.758, 0.884, and 0.898, respectively.

Depression, Anxiety, and Stress Scale (DASS-21): This scale, developed by Lovibond and Lovibond (1995), is a set of three self-report scales to assess negative emotional states in depression, anxiety, and stress. This scale measures the severity of the main symptoms of depression, anxiety, and stress. This scale has 21 items (depression 7 items, anxiety 7 items, and stress 7 items) that the subject answers on a 4-point Likert scale from never = 0 to always = 3. Lavibund and Lavibund (1995) used factor analysis to examine the construct validity of this tool, which confirmed the existence of three factors depression,

anxiety, and stress. The results of the factor analysis by Antony et al. (1998; quoted by Samani & Jokar, 2007) have also shown that 68% of the total variance of the scale is measured by three factors depression, anxiety, and stress. The eigenvalues of depression, anxiety, and stress in the research of Anthony et al. (1998; cited by Samani & Jokar, 2007) were 2.89, 1.23, and 9.07, and the alpha coefficient for these factors were 0.92 and 95, respectively. Samani and Jokar (2007) have examined the validity and reliability of the Persian version of this scale. In the study of validity through convergent validity between the depression subscale of the DASS questionnaire with the components of insomnia, anxiety, and insomnia syndrome, social dysfunction, and depression of the general health questionnaire, the correlation coefficients were 0.58, 0.55, 0.13, and 0.55, respectively, between the anxiety subscale with the above components, were 0.50, 0.63, 0.16, and 0.47, respectively, and between the stress subscale and

the mentioned components have reported 0.23, 0.30, -0.13, and 0.10, respectively. For physical Syndrome, Anxiety, Insomnia, and depression, the General Health Questionnaire is significant. Samani and Jokar (2007) used the retest method for depression, anxiety, and stress subscales to be 0.81, 0.78, and 0.80, respectively, and Cronbach's alpha for the depression, and anxiety subscales, and reported stress of 0.85, 0.75, and 0.87, respectively. In the present study, Cronbach's alpha for each of the subscales of depression, anxiety, and stress was 0.905, 0.888, and 0.893, respectively.

Date Analysis

Both groups were administered pre-tested, and the experimental group underwent a 90-minute treatment group for eight sessions per week (groups of 9 people consisting of three families, and each family according to the purpose of the study included three teenagers with their parents), but the control group did not

Table 1. Summary of social-emotional teaching program (Sadri Demirchi, Navidi & Pourshaneh, 2010)

meeting	Description of meetings
Session1	Introduction and pre-test: Introduction and acquaintance with group members, expression of group rules, discussion about the importance of social-emotional skills, and people's feedback on how to introduce.
Session2	Self-awareness: observing and recognizing emotions and naming them, recognizing the difference between emotions and feelings, becoming aware of the connection between thoughts, feelings, and reactions, and finding words to express emotions.
Session3	Recognizing emotions and naming: Recognizing the way of expressing emotions and being aware of them in interpersonal relationships, evaluating and recognizing emotional states, and accepting responsibility for your emotions.
Session4	Interpersonal Relationships (Communication): Talking about emotions effectively, becoming a good listener, distinguishing between what others say and do, their reactions and judgments towards them, and sending messages that start with me Can be blamed instead.
Session5	Empathy: Understanding the feelings and interests of others, considering their mental perspective, respecting the differences between people in different phenomena, coping with stress, the effect of stress on other aspects of life, teaching coping techniques, And calming oneself in times of stress, getting acquainted with the stages of stress, determining the role of one's perceptions in creating stress.
Session6	Flexibility in the face of change: The need for flexibility in achieving one's goals and adapting to the environment and change, how to adapt and be flexible in the face of change.
Session7	Emotion control: The role of emotion control in people's performance, controlling emotions effectively, signs and symptoms of anger expression, methods of expressing anger in individuals, effective methods of expressing anger and expressing it correctly.
Session8	Assertiveness: The difference between assertiveness and aggressive behavior, identifying behaviors that indicate assertiveness, and skills to increase assertiveness. Provide a summary of the content, summary, and post-test.

receive any intervention. Post-test data were collected from both groups and for three months both groups were followed up. Repeated variance analysis was used to analyze the data. All analyzes were performed using SPSS-21. A summary of group therapy sessions is provided in Table 1.

Results

In the present study, 30 adolescents (15 in the experimental group and 15 in the control group) participated in the study with their parents. In terms of fathers' jobs in both experimental and control groups, 5 (33.3%) were unemployed, 4 (26.7%) were workers, 2 (13.3%) were employees, and 4 (26.7%) were self-employed. In terms of socioeconomic status in the experimental group, 7 (46.7%) had low socioeconomic status, 6 (40%) had moderate status, and 2 (13.3) had high socioeconomic status. In the control group, 6 (40%), 5 (33.3%), and 4 (26.7%) had low, medium, and high socio-economic status, respectively

. Table 2 shows the mean and standard deviation of the subjects' scores in the pre-test, post-test, and follow-up by experimental and control groups. Also, according to the results of the Kolmogorov-Smirnov and Shapiro-Wilk tests, which show that the significance level is higher than 0.5, the data distribution of all research variables is normal. Then, the Levin test was used to evaluate the homogeneity of variance between groups, the results of which are presented in Table 3.

According to the results of Table 3, the assumption of homogeneity of intergroup variances is established. Then, to test the data sphericity hypothesis, the Mochley sphericity test was used, the results of which were used to express positive emotion ($W = .870$, $\chi^2 = 3.76$ & $P = .153$), to express intimacy ($W = .892$, $\chi^2 = 3.08$ & $P = .214$), negative emotion expression ($W = .971$, $\chi^2 = .800$ & $P = .670$), depression ($W = .887$, $\chi^2 = 4.46$ & $P = .103$), anxiety ($W = .838$, $\chi^2 = 4.77$ & $P = .092$) and

Table 2. Mean and standard deviation of research variables by two groups

Variables		examination Group		control group		Kalmogrov-Smirnov		Shapiro-Wilk	
		M	SD	M	SD	statistics	P	statistics	P
Express positive emotion	Pre-test	15.33	3.08	16.13	2.82	.103	.200	.966	.440
	Post-test	22.60	3.45	16.46	2.74	.158	.056	.964	.387
	Follow up	22.33	4.04	16.53	2.72	.105	.200	.949	.128
Express intimacy	Pre-test	10.86	1.45	11.13	1.35	.133	.159	.954	.214
	Post-test	16.93	1.09	11.33	1.75	.154	.067	.943	.108
	Follow up	16.73	1.48	11.20	1.69	.153	.071	.939	.092
Express negative emotion	Pre-test	15.20	2.36	15.46	2.50	.156	.069	.938	.087
	Post-test	9.60	2.50	15.33	2.53	.155	.061	.939	.092
	Follow up	9.93	2.31	15.06	2.40	.157	.057	.940	.089
Depression	Pre-test	13.26	2.60	13.20	2.65	.140	.139	.947	.157
	Post-test	8.13	2.41	13.46	2.61	.145	.109	.942	.103
	Follow up	8.40	2.26	13.33	2.49	.151	.078	.938	.087
Anxiety	Pre-test	13.46	2.32	13.40	2.41	.153	.082	.935	.069
	Post-test	7.93	2.34	13.06	2.43	.110	.200	.970	.532
	Follow up	7.73	2.15	13.46	1.88	.103	.200	.954	.215
Stress	Pre-test	13.33	1.87	13.13	2.66	.140	.139	.954	.214
	Post-test	7.26	1.38	13.40	2.79	.137	.156	.938	.087
	Follow up	7.47	11.72	13.15	2.29	.151	.078	.936	.071

Table 3. Levin test to examine the homogeneity of variances

Variables		F	DF1	DF2	P
Express positive emotion	Pre-test	.486	1	28	.491
	Post-test	2.484	1	28	.126
	F0llow up	2.221	1	28	.146
Express intimacy	Pre-test	.003	1	28	.960
	Post-test	2.517	1	28	.124
	F0llow up	.014	1	28	.907
Express negative emotion	Pre-test	.011	1	28	.916
	Post-test	.018	1	28	.893
	F0llow up	.065	1	28	.801
Depression	Pre-test	.006	1	28	.939
	Post-test	.304	1	28	.586
	F0llow up	1.135	1	28	.296
Anxiety	Pre-test	.374	1	28	.546
	Post-test	.001	1	28	.970
	F0llow up	.345	1	28	.562
Stress	Pre-test	3.102	1	28	.089
	Post-test	1.823	1	28	.174
	F0llow up	2.939	1	28	.098

stress ($W = .956$, $\chi^2 = 1.20$ & $P = .548$) which show that the homogeneity of the variance-covariance matrix of the dependent variables is observed, and the assumption of data sphericity is established ($0.05/0 < P$). Therefore, the results of intra-group tests can be used without adjusting the degree of freedom.

The results of Table 4 show that there is a significant difference between the scores of emotional expression and psychological disturbance (in the pre-test, post-test, and follow-up) between the experimental and control groups ($P < 0.01$). Based on the results of repeated measures analysis of variance, family empowerment has been effective on at least one of the variables.

Table 4. Results of multivariate indices of analysis of variance with repeated measures for intergroup effects

Source	Test	Value	F	DF Hypothesis	DF error	P	Squared
group	Pillay effect	.845	20.846	6	23	.001	.845
	Lambda Wilke	.155	20.846	6	23	.001	.845
	Hoteling effect	5.438	20.846	6	23	.001	.845

Table 5. Summary of the results of analysis of variance with repeated measures to compare the scores of the three stages in the experimental and control group

Variables	Source of changes	Total changes	DF	Average squares	F	P	Squared
Express Positive expression	levels	281.40	2	140.70	153.75	.001	.846
	Within-group	229.35	2	114.67	125.32	.001	.817
	Between-group	309.87	1	309.87	10.84	.003	.279
Express intimacy	levels	186.47	2	93.23	211.28	.001	.883
	Within-group	171.16	2	86.08	192.80	.001	.873
	Between-group	295.21	1	295.21	50.91	.001	.645
Express negative emotion	levels	162.46	2	81.23	189.19	.001	.871
	Within-group	134.82	2	67.41	157.02	.001	.849
	Between-group	309.87	1	309.87	18.27	.001	.395
Depression	levels	115.26	2	57.63	133.01	.001	.826
	Within-group	135.80	2	67.90	156.69	.001	.848
	Between-group	260.10	1	260.10	14.40	.001	.340
Anxiety	levels	166.42	2	83.21	141.30	.001	.835
	Within-group	152.60	2	76.30	129.56	.001	.822
	Between-group	291.60	1	291.60	20.46	.001	.422
Stress	levels	170.15	2	85.07	213.54	.001	.884
	within-group	186.86	2	93.43	234.51	.001	.893
	Between-group	336.40	1	336.40	24.86	.001	.470

The results of Table 5 show that family empowerment has a significant effect on emotional expression and psychological disturbance of adolescents with parents with substance abuse in the post-test stage and follow-up of the experimental group ($P < 0.05$). Therefore, it can be said that family empowerment based on socio-emotional learning had a significant effect on improving emotional expression and psychological disturbance in adolescents in the experimental group compared to the control group. In addition, the square of the ETA parasite shows

that 27.9%, 64.5%, 39.5%, 34%, 42.2%, and 47% of the variance in changes in positive emotion expression, intimacy expression, negative emotion expression, and depression, respectively. Anxiety and stress in the experimental group were caused by family empowerment based on socio-emotional learning. Considering that the effect of interaction between intragroup factor and intergroup factor was significant, the simple intergroup effect concerning intragroup factor levels was investigated using Bonferroni correction, the results of which are

presented in Table 6.

The results of Table 6 show that the difference between the means between the test situations, i.e. the difference between pre-test and post-test and

and psychological injuries, and this effect was stable in the three-month follow-up. This finding is in agreement with the findings of previous studies such as Cejudo et al. (2020), Ratcliffe et al.

Table 6. Benferoni adjustment test to compare the scores of pre-test, post-test and follow-up stages.

Variable	levels	The difference between the means	standard error	P	
Express positive emotion	Pre-test	Post-test	-3.80*	.219	.001
		F0llow up	-3.70	.288	.001
	Post-test	F0llow up	.177	.229	.930
Express intimacy	Pre-test	Post-test	-3.13*	.152	.001
		F0llow up	-2.96*	.197	.001
	Post-test	F0llow up	.167	.167	.940
Express negative emotion	Pre-test	Post-test	2.86*	.180	.001
		F0llow up	2.83*	.171	.001
	Post-test	F0llow up	-.133	.155	.960
Depression	Pre-test	Post-test	2.43*	.149	.001
		F0llow up	2.36*	.205	.001
	Post-test	F0llow up	-.165	.147	.935
Anxiety	Pre-test	Post-test	2.93*	.210	.001
		F0llow up	2.83*	.223	.001
	Post-test	F0llow up	-.131	.154	.920
Stress	Pre-test	Post-test	2.90*	.146	.001
		F0llow up	2.93*	.175	.001
	Post-test	F0llow up	.157	.167	.860

(* = $P < 0/05$ & ** = $P < 0/01$)

pre-test with follow-up is significant ($P < 0.01$), but the difference between the mean between post-test and follow-up is not significant in research variables ($P < 0.05$). This indicates that the results of the intervention in the quarterly follow-up phase were also stable.

Discussion and conclusion

The present study aimed to determine the effectiveness of family empowerment based on social-emotional learning on emotional expression and psychological damage in adolescents with substance abuse parents. In this regard, the results of the present study showed that empowering the family with a social-emotional learning program had a significant effect on emotional expression

(2014), and Mokarram et al. (2014). This finding is consistent with the findings of previous studies such as Golrokh and Naomi (2019), Hosseini (2018), and Mehdiانfar et al. (2014).

In explaining the effectiveness of family empowerment based on social-emotional learning on the mental injuries of teenagers with substance-dependent parents, it can be said that training appropriate social-emotional skills and providing opportunities and experiences that social and family interactions increase in these adolescents allows them to practice and apply social strategies and skills in all environments and real-life situations (Gooding, 2011). Adolescents who learn social-emotional skills and establish strong relationships with family and community members will most

likely show a high level of adjustment and mental health. Adolescents who acquire social-emotional skills well and show more socially desirable behaviors have a more positive self-concept that causes them to understand their limitations and abilities, evaluate, understand, and accept more correctly, considering the role of emotions in psychopathology and mental health (Tull, Gratz, McDermott, et al., 2015).

Teaching adaptive emotional skills can play an important role in their adaptation, balance, and mental health by increasing emotional awareness and appropriate emotional and interpersonal relationships between family members and between parents and their children. According to the findings of Baurain and Nader-Grosbois (2013), regarding the relationship between social information processing and social-emotional regulation, social-emotional skills training can improve social information processing and social interactions of adolescent improve which lead to an increase in social support in teenagers. According to the existing theories, social support has a role in increasing mental health and improving mental disorders and can improve mental disorders.

In addition, positive psychology theories define life skills as a potential protective factor and promote mental health. While the World Health Organization (2004) defines social-emotional learning as a set of life skills. In the same way, social-emotional learning programs are considered one of the most successful interventions for the positive and integrated development of adolescent personality (Durlak, Weissberg, Domitrovich & Gullotta, 2015) whose purpose is to improve the quality of life and well-being of people (Pérez-González, Qualter 2018; Domitrovich, Durlak, Staley & Weissberg, 2017). Therefore, promoting the social and emotional well-being of adolescents through social-emotional learning can be a determining factor in their positive development, which allows them to achieve positive results in their family and

society, and in life in general (Durlak et al., 2015) and in this way it can have a positive effect on their psychological injuries and emotional expression.

On the other hand, teaching social-emotional skills in the form of family empowerment in the first place can improve the communication and emotional abilities of each family member and the emotional atmosphere of the family by influencing relationships between family members and improving emotional expression. Therefore, empowering the family with socio-emotional learning can improve the styles of expressing positive emotions and expressing intimacy and reduce the expression of negative emotions in the family by creating awareness of emotions and how to express and control them among family members. This can increase emotional support between family members by increasing appropriate and constructive relationships between family members and reducing the underlying and revealing factors of psychological disturbance in adolescents. Explaining the effectiveness of family empowerment with social-emotional learning programs on the emotional expression of adolescents with substance-dependent parents, it can be said that teaching social-emotional skills lead to the person being aware of emotions and expressing emotions (Cejudo et al., 2020). Especially positive emotions in life situations reduce their negative feelings and emotions, as a result of which the rate of adolescent adjustment in social, emotional, and family dimensions will improve. In other words, adolescents with substance-dependent parents evaluate themselves negatively in social and family situations that engage less in social and family situations, the negative effects of which can lead to problems in social, emotional, and family adjustment. But empowering the family with socio-emotional skills makes adolescents and family members aware of the existence of negative emotions and how to express negative emotions and their impact on themselves, and by re-evaluating

their emotions in different situations and express positive emotions and intimacy to try to keep their emotional life healthy, which can improve family adjustment and mental health in adolescents with substance-dependent parents and their family members.

Due to the inevitability of limitations in scientific research, the present study also faced limitations, the most important of which was not to involve all family members in the treatment process, and the use of self-report tools to measure research variables. He pointed out the implicit and obvious bias in it and the relatively low sample size, which limits the generalization of the results. Therefore, it is suggested that in future research, if possible, all family members be involved, use tools such as surveyed interviews and behavioral assignments to measure variables, and also study a larger sample size. Also, considering the effectiveness of family empowerment with socio-emotional learning programs on psychological disturbance and emotional expression, it is suggested that family therapists and therapists of children and adolescents treat and reduce the disturbance of drug-dependent parents. Adolescents enter to seek out family empowerment based on socio-emotional learning.

Conflict of interest and acknowledgments

The authors claim that there is no conflict of interest in the study. The authors would like to thank the participants who cooperated in the research.

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