PERCEPTIONS OF THE SIGNIFICANT OTHERS LIVING WITH AN ADULT FAMILY MEMBER EXPERIENCING REOCCURRING RELAPSE FROM SUBSTANCE USE: A SOCIAL WORK PERSPECTIVE

by

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DECLARATION

I declare that the study: **Perceptions of the significant others living with an adult family member experiencing reoccurring relapse from misuse: A social work perspective** is my own work and that all the sources that I have utilised have been indicated and acknowledged.

Signature:  **Date:24.05.2023**

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LIST OF ABREVIATONS

CDA	Central Drug Authority
Dr F and F	Dr Fabian and Florence Ribeiro Treatment Centre
IDP	Individualised Treatment Plan
NDMP	National Drug Master Plan
NDSD	National Department of Social Development
NGO	Non-Governmental Organisation
NIAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
SAPP	Substance Abuse Prevention Programme
SAPS	South African Police Service
SASSA	South African Social Security Agency
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
WO	Welfare Organisation

ABSTRACT

The use of substances is a big challenge globally. Despite prevention, treatment, and aftercare programmes to eradicate this phenomenon, individuals often relapse within months after completing their treatment. The recurring relapses are not only costly to the country, but they also affect the health of the family members of users who experience tension, uncertainty, and anxiety to such an extent that it becomes life-threatening. The continuous consumption of substances leads to addiction, and this causes more stress and discord within the family.

The purpose of this study was to explore, identify, and describe the perceptions of significant others living with an adult family member experiencing reoccurring relapse from substance misuse. This study was found that service users experiencing reoccurring relapse because of numerous factors such as the absence of the parents in their lives, lack of motivation and direction, unemployment, and peer pressure. Therefore, the study recommended that inpatient centre should offer better services and it also eradicate self- discharge policy, and it should improve security services because service users are using while in the centre.

Fourteen women and three men participated in the study. The researcher gathered data by conducting face-to-face interviews with the participants. Data were analysed thematically. Furthermore, data verification and theoretical frameworks were used. The ethical issues involved when conducting the research, namely informed consent, anonymity, confidentiality, avoidance of harm, and management of information. Lastly, the researcher proffered recommendations on the findings.

Keywords: adult, family, perception, relapse, service users, significant others, substance use.

CHAPTER 1

GENERAL ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter provides a background to the study on the perception of significant others living with adult family member experiencing reoccurring relapse from substance misuse.Families are important in supporting substance users and using substance can affect the life of the substance users and their family members for example: social, physical, financial and legally (MacCann, Lubman, Boardman & Flood,2017, p. 2) It gives the statement problem, the rationale of the study, a brief outline of the research methodology, and the outline of the report.

1.1.1 Background to the study

The use of substances seems to be a big challenge globally (Kadkhodaei, Akbari & Sokut, 2015, p.5). It is estimated that 5.6% of the global population (about 275 million) aged between 15 and 64 have used substances at least once (Mazhnaya, Bojko, Marcus, Fillippovych, Islam, Dvoriak & Altice, 2016, p. 163). For instance, the Ukraine is reported to have the highest number of people who are using drugs, at an estimated 310 000. Furthermore, Sahker, Acion and Arndt (2015, p.118) highlight that, in the United States of America (USA), substance use places college students at high risk of poor performance, dropping out of college, incurring injuries, and even death. A recent large epidemiological study found that college students between 18 and 24 years of age are among the heaviest drinkers (Sahker et al., 2015, p.118). Similarly, Malini, Shamsudin and Wahab (2019, p. 51) postulate that, since 1983, Malaysia has also experienced a big challenge with substance use. In 2016, Malaysia was reported to have the highest number of substance use disorder cases, jumping from 4280 in 2015 to 5081 (Malini et al., 2019, p. 51). Fang, Barnes-Ceeney and Schinke (2011, p. 642) indicate that Asia is also experiencing the same problem, further highlighting that the

rate of binge drinking is 33.6% among Asian girls and 30.6% among Asian boys. China is also experiencing an enormous challenge of dealing with substance use disorder (Min, Xu, Chen, Ding, Yi & Mingyang, 2011, p.141).

On the African continent, Zimbabwe is also facing this phenomenon. It was reported that Zimbabwean children as young as 13 years old are drinking and that this phenomenon is increasing and affecting more and more communities in Zimbabwe (Chirisa, 2014, p. 82). South Africa is equally affected using illegal substances. The National Drug Master Plan (2013–2017, p.12) states that the use of substances in South Africa is more prevalent and it is becoming a serious challenge. Similarly, the CDA Annual Report (2012/13, p. 12) indicates that the rate of substance use in South Africa is very high, and the use of illicit drugs is twice that of the global average. South Africa is also amongst the top 20 countries in the world with the highest alcohol consumption (Department of the Premier Western Cape Government, 2017, p. 11).

This makes South Africa the third-biggest drinking nation in Africa. It is estimated that South Africans consume 27.1 litres of pure alcohol per person per year, which equates to 80% more alcohol per person than in Brazil, and this number is expected to increase by 12.1 litres per drinker between now and 2025 (Department of the Premier Western Cape Government, 2017, p. 10). In a report by Eberlein (Parliamentary Monitoring Group, 2011) on substance use and abuse in South Africa, it was revealed that 65% of the South African rural communities admitted that they are using drugs in their homes. The most frequently used drugs were alcohol, cannabis, and tobacco. Glue was most common amongst adult substance users, as it helps them to keep warm and makes their stomachs feel full. *Tik*[1] was most frequently used in Cape Town and was not widely used in other parts of the country.

The so-called war on drugs has resulted in many countries forming programmes against drug use and responding to the challenges of substance use with the view to

[1] *Tik is a white or crystalline powder that is easily manufactured from available chemicals (Carelse, 2018, p. 2).*

eradicating this phenomenon (National Drug Master Plan, 2012, p. 48) For example: Burwell (2016, p. 3) indicated that the USA developed programmes to prevent or reduce the starting of early substance use, focusing on the harmful effects caused by the use of substances. These programmes are modelled on the Prevention Service Delivery Model System, to promote health development, improve outcomes and reduces substance use and other problems related to substance use by the service user.

This prevention programme is divided in the following categories (Burwell, 2016, p. 3):

a) **Universal prevention intervention:** Universal prevention intervention focuses only on the service user. It reduces the specific health problems of the service user.
b) **Selective prevention intervention:** This programme is rendered to families, children and communities that are at high risk of using substances, for example, poor families and children who have difficulties with social skills.
c) **Indicated prevention intervention:** This programme focuses on those who are already using substances but still can control their behaviour. (Not yet addicted to the drugs).

African countries also have programmes to eradicate substance use. There is an unnecessary drug policy in certain countries (Republic of Congo, Egypt, Libya, South Sudan and Sudan) where these countries apply the death penalty to the service user, even though this is against the human rights. Change in this area is still a challenge because of the lack of research in many countries relating to substance use.

Zimbabwe has its own way of dealing with substance use. For example, there is no needle and syringe programme. It is not seen as a priority because there is no spread of injecting substance. Zimbabwe also does not offer the opioid substitution therapy; only wealthy people can travel to South Africa to access private treatment (Don’t treat us as outsiders, 2019, p. 40). For the country to offer this programme, the data of the service users injecting themselves and those who are using opioids need to be collected, so that they can develop this programme (Don’t treat us as outsiders, 2019, p. 40).

South Africa is an important player in the African continent and globally to tend to the substance use problem. The National Department of Social Development (2011, p. 21) highlighted that South Africa has developed the following programmes to deal with the challenge of substance use:

a) **Level 1 (Prevention)** (outreaches and awareness programmes) In the prevention programme, the service users and their families receive services and resources that are relevant to the services to promote resilience and growth in their lives. It prevents the service users and their families from being dependent on substance.
b) **Level 2 (Early intervention)** In this programme, attention is given to individuals who are at high risk of substance use. Those who are already addicted to substances are referred to the rehabilitation centres, where the service users will be admitted according to the inclusion and exclusion criteria of the centre. These will be identified through the pre-admission screening.
c) **Level 3 (Continuum of care treatment)** This programme is the last one, where the service user will be in the rehabilitation centre. The service user will be assessed according to their physical, psychiatric, and psychological needs. Assessment is different. For example, intake assessment is done by medical practitioners. Comprehensive assessment is done by qualified, experienced professionals trained to assess psychiatric service users and the normal is assessment done by case managers (social workers). The social workers must do an IDP (individualised treatment plan). It is important to plan with the service user because it encourages them to participate; it motivates them in their recovery. The programme models apply to structure the weekly and daily activities of individuals, and group therapy/counselling.

Although many countries have declared war on substance use, not all countries are dealing with this phenomenon in the same way. Some countries do not have enough resources to solve the problem because of other competing priorities, consequently

increasing the risk of public disaster (CDA Annual Report, 2012/2013, p. 12). A developed country such as the USA, for example, spends an estimated $9.4 billion on the treatment of illicit substance use (Olsson et al., 2015, p. 2). In China, the government shifted the responsibility of service users from the Department of Justice to the Department of Health (Min et al., 2011, p. 141). Furthermore, Farzizadeh (2015, p. 216) indicated that, in Iran, the families of service users do not get any kind of support from the government.

However, the issue of this phenomenon in South Africa is not only a concern for the South African Government, but for non-governmental organisations (NGOs) as well. Thus, NGOs in South Africa are advising the CDA on strategies and they are also involved in policymaking (National Drug Master Plan, 2013–2017, p. 129)

The South African Government has established rehabilitation centres and programmes (prevention, treatment, and aftercare) to eradicate this epidemic. For example, the Dr Fabian and Florence Ribeiro Treatment Centre offers inpatient treatment; the Witpoort Care Centre offers treatment for *nyaope*[2] users who experience severe physical discomfort during their detoxification programme; the Cape Town Rehabilitation, Drug, Alcohol, Addiction Treatment Centre offers treatment for substance use and a behaviour modification programme; and the Seshego Treatment Centre offers inpatient treatment for substance use. Some of the private rehabilitation centres include The Way Recovery, which offers inpatient and outpatient treatment programmes; the Polokwane Rehabilitation Centre, which offers residential treatment and long-term sobriety treatment, and Phoenix House, which offers treatment for outpatients.

Prevention programmes are carried out in the form of awareness or outreach programmes, and they primarily target individuals who are not yet using substances (National Department of Social Development 2011, p. 21). There are substance use prevention programmes, such as the Ke-Moja Substance Abuse Prevention

[2] *Nyaope is a narcotic drug that is manufactured with different substances, including low-grade heroin and cocaine (*Motsoeneng 2018, p.1).

Programme. Such prevention programmes prevent the target groups from becoming service users and strengthen vulnerable families and young people (National Department of Social Development, 2011, p. 21).

The programmes can link individuals and families to resources, and they aim to reduce and prevent the harmful effects of the use of alcohol and other drugs. The CDA highlights that harm reduction or decreasing the need for substances through prevention programmes includes educating target groups, making the use of substances conventionally unwanted, and developing boundaries on the use of substances (CDA Annual Report 2012/2013, p. 21). However, it has been widely observed that prevention programmes have failed to achieve the goal of eradicating this phenomenon (Nazari, Jamshidi, Rahimi & Cheragi, 2016, p. 175). If the prevention programmes do not yield the intended outcomes or fail outright, then a treatment programme is needed.

Treatment programmes are useful in assisting the individual who is already using a substance. The treatment programmes are good at addressing treatment goals and are supported by appropriate activities and routines. These activities, which include therapeutic and counselling sessions, require a minimum of 40 hours per week (National Department of Social Development 2011, p. 34). There is a treatment process model which focuses on the coordination of service delivery. This model uses behavioural and cognitive therapy to bring about change in the individual and it also focuses on the needs of the individual when referring them to aftercare (Van Der Westhuizen, Alpaslan & de Jager, 2011, p. 353).

In the second week, the service user will be allocated to a social worker. The ratio is 1:15 social worker to service users (National Department of Social Development, 2011, p. 27) This ratio is not workable because, as already mentioned, they are allocated to the social worker in the second week. They mix all the service users, nyaope users with rock users or dagga users in the same group. This causes a challenge because nyaope users take time to withdraw and other service users who are not using nyaope will not

be experiencing withdrawals. Some of the nyaope users come in and out the hospital meaning they miss some of the programme, and to extend the programme is also a challenge to the social worker because when it is time to discharge the users, there are new admissions allocated to them. It is better to recommend to the outside social worker or to the probation officer rendering aftercare services the element that they must focus on. However, there is the possibility of aftercare not happening or of the service user deciding not to attend.

There are many contributing factors such as the aftercare being far from the service user and the family having financial problems, meaning they cannot afford transport money. Another point is that sometimes there will be a behavioural management team meeting for the whole day. This could disrupt the intention of the social worker who might have planned to consult with three individuals for therapy sessions that day. The social workers sometimes go for training for two weeks and then they are forced to rush the process to meet the requirements of the department. Before going to training the social worker must make sure she renders individual and group sessions for three weeks within one week with regard to whether the service users are coping or not.

The researcher believes that 1:6 or 1:8 ratios per social worker can be workable but only if they have auxiliary social workers. Otherwise, it is as if the social worker is a petrol attendant: she is just working to fill up the tank. Therefore, a six-week programme is not long enough for service users. The drafted weekly and daily activities, for example, individual and group therapy, in a time-limited programme, like a six-week programme (National Department of Social Development 2011, p. 29) are as follows: The social worker must aid the service user for the period of six weeks in the centre by assisting the service user to develop their treatment goals, meeting weekly with the service user for a minimum of 30 minutes, and offering support and crisis intervention (National Department of Social Development 2011, p. 29).

However, the International Standards for the Treatment of Drug Use Disorder (United Nations Office on Drugs and Crime, 2017, p. 2) indicate that, despite the severity of the

use of substances, it has been established that not all service users are receiving treatment. For instance, in Latin America, only one out of 11 service users were receiving treatment, and in Africa it was only one out of 18 service users (United Nations Office on Drugs and Crime 2017, p. 2). On the other hand, the nature of substance use demands that the treatment period for individuals experiencing this phenomenon in rehabilitation centres should be long enough to be effective in producing positive change (United Nations Office on Drugs and Crime 2017, p. 4).

Because a substance use is a combination of biological, psychological, and social factors, the treatment should focus on all the needs of the service users for the outcome to be successful (National Institute on Drug Abuse, 2014, p. 28). It will require different professionals to address the substance use phenomenon appropriately during the treatment programme (National Drug Master Plan, 2012, p. 10).

After- care programme

After completion of the treatment programme, service users are referred to aftercare programmes on an outpatient basis. An aftercare programme is a service that offers ongoing support to maintain sobriety, abstinence, and personal growth, and it assists with reintegration into the community/family (National Department of Social Development, 2011, p. 13). It also offers individual therapy and support groups, and during support groups individuals share their ideas and experiences regarding their addiction.

However, relapse is still a major challenge, since individuals often relapse within a few months after completing their treatment programme (Yang, Zang, Bi, He, Gao & Xi, 2017, p. 320). It seems as if aftercare programmes have failed because service users repeatedly relapse.

Relapse is experienced by up to 75% of intoxicant-dependent service users with six months of an index treatment episode (Adinoff et al., 2016, p. 87). Li et al. (2015, p. 968) state that the relapse rate is 70% after the service user has left the treatment programme. It has further been estimated that about 50% of the service users who

undertook the detoxification process relapsed within three months (Gupta, Khan & Krishna, 2017, p. 324). This relapse inevitably affects the whole nation, as finances must then be utilised to assist the same people. Reid (2009, p. 2) asserts that between 40% and 60% of treated service users relapse within a year of receiving treatment. On the other hand, the National Institute on Alcohol use and Alcoholism (NIAAA) (2017, p. 17) estimates that nearly 90% of people in recovery from alcohol use relapse at least once in a four-year period. The institute also reports that relapse rates for people in recovery for all types of substance use average at between 40% and 60% (NIAAA, 2017, p. 81).

Individuals who are repeatedly admitted to the treatment programme reportedly had more severe levels of substance and/or injection drug use, as well as higher levels of criminality, than service users with only one admission and service users who were initially abstinent after completing a substance treatment programme (Grahn, Chassler & Lundgren, 2014, p. 1764). Recurring relapses can occur as a result of biological factors, e.g., neurotransmitters in the brain, or many other environmental factors which encourage the individual to repeat the same behaviour (Van Zyl, 2017, p. 13). Donovan and Witkiewitz (2012, p. 204) highlight that many treatment professionals, as well as alcohol- and drug-dependent individuals, have observed relapse as a predictable result in the sense of doubt about the treatability and long-term prognosis of addictive behaviours.

According to Ahari (cited in Nazari et al., 2016, p. 175), 8% of service users relapse before they even reached six months of sobriety. Hence, the American government decided to introduce traditional approaches to educate the service users about high-risk situations that can cause them to relapse. However, this never normalises the situation. The Welfare Organisation (cited in Nazari et al., 2016, p. 175) has stated that about 90% of service users who give up the behaviour of using substances return to the same behaviour eventually and their sobriety does not last for more than a few weeks or months. Relapse prevention is a major challenge in the treatment of substance use. It seems as if substance use has a long-term effect on recovery, as service users who

repeatedly relapse are those who have successfully completed the treatment programme. In terms of the experience of the social workers, when service users are on their journey to recovery, they find themselves having much time on their hands because during their addiction time, they were spending most of the time hustling.
The following developmental stages of recovery (early recovery, middle recovery, and late recovery), according to O'Sullivan, Xiao, and Watts (2019, p. 210), are experienced by service users during their recovery.

Early recovery is the first development stage of recovery. It is the first step of abstaining from substances and it lasts approximately three months. At this stage, the service users are at high risk of relapse. The service user must focus on their goal of maintaining sobriety.

Middle recovery is the second developmental stage of recovery; characterised by the stable behaviour of the service users as they are starting to gain more confidence about their sobriety. The service users are more focused on their future. However, the service users can still relapse, but the chances are few compared to during early recovery. This stage includes stabilisation and life balance.

The last developmental stage is **late recovery.** The service users put less attention on abstinence and less emphasis on relapse prevention because this developmental stage has the greatest stability. More of the focus of the service users is on their growth. Even though this stage has the lowest risk for relapse, the minority (25%) of the service users are still reporting relapse after a long time of sobriety in recovery.

The CDA (2012/2013, p. 2) indicates that service users often lose interest in relationships, they isolate themselves from their family members, social lives, studies, work, and recreational activities, and they may continue engaging in high-risk behaviours by repeatedly using substances.

South Africa is experiencing a high rate of relapses in substance use e.g., in the Western Cape, 43% of service users treated for heroin dependence were readmissions and 28% of service users treated for methamphetamine dependence in Gauteng had been admitted before (SACENDU, 2019, p.8). Therefore, relapse in South Africa is a big challenge to be taken into consideration.

1.1.3 Problem statement

The problem statement entails identifying an existing phenomenon that the researcher has decided to investigate so that they may come up with a solution (DeForge, 2012, p. 2). De Vos et al. (2011, p. 94) advise that the problem statement should be divided into several questions that should give direction to the objectives and goals of the study.

A review of the existing literature on the association between substance use and recurring relapses has been conducted. Some of the studies that considered substance use in relation to recurring relapses include those by Li et al (2014), Min et al (2011), Nazari et al (2016), and Malini et al (2019), and all these studies focused on methadone maintenance treatment as a therapy/treatment to prevent relapse. Other authors and scholars (Chirisa, 2014; Calafat Juan, Beconia & Garcia., 2014; Piko & Balázs, 2012; Valente, Cogo-Moreira & Sanchez, 2017) have placed their focus on family relationships and how these relationships influence the use and abuse of substances by adolescents.

According to Choate (2015, p. 462), addiction affects the functioning of the family, and it changes the relationships between family members, including the tasks that each member performs. Similarly, Smith and Estefan (2014, p. 14) report that significant others with substance using family members regularly visit clinics or hospitals because they are being affected physically and psychologically, with elevated stress symptoms, such as depression, anxiety, and trauma being prominent. South Africa is also experiencing the same challenges that are mentioned above. Motsoeneng (2018, p. 8) indicates that, in South African families, the behaviour of the service user affects their family members negatively. Similarly, Charlton, Negota and Mistry (2019, p. 42) highlight that South Africa has a large problem of substance use and that this does not

only affect service users but also their families, friends, colleagues, and the whole community.

As has already been emphasised, a few studies revealed that, after the service user has completed the programme, they return to their previous behaviour within a few weeks or months, or even a year later (Gupta et al., 2017; NIAAA, 2017; Yang et al., 2017). The phenomenon of relapse becomes a threat to rehabilitation centres, as they are already congested. South Africa is experiencing the same situation as it lacks the infrastructure to administer the suppliers. It also does not have enough treatment centres and professionals to deal with the increasing number of service users (Motsoeneng, 2018, p. 10). In South Africa, most literature focused more on service users and substance use in general; however, this problem does not only affect the service users but also their families and communities (Motsoeneng, 2018, p. 8).

South Africa is a developing country, and it needs strong and healthy people to be productive in their economy, but if they are using substances their mental well-being will be affected negatively, and they are not able to be productive, which will decrease the productivity of the country. Thus, there is a need for qualitative research to explore the perceptions of significant others about adult family members relapsing and being readmitted into treatment centres.

Therefore, the problem statement for this study reads as follows: Although there are studies that have investigated substance use in relation to relapse, studies investigating the perceptions of significant others living with an adult family experiencing relapse from substance misuse seems to be limited.

1.1.4 Rationale for the study

There are two significant factors that motivated the researcher's interest in this area, namely professional experience, and the lack of documented research on the topic. The researcher is currently employed as social worker rendering services at an inpatient treatment centre for service users with substance use problems. The researcher also

provides a prevention programme to the community, assists with family reunification, and offers family preservation services.

The service users can be admitted, voluntarily or involuntarily. The programme duration is only six weeks and during the first week of treatment the medical staff monitors the service users' situation by giving them detoxification medication to reduce the harmful effects of the substances, to help them cope with withdrawal symptoms. The service users are allocated to social workers from the second week of the programme; hence, social workers manage all the cases of service users to ensure that the rights of the service users are not violated.

Social workers are required to assess newly admitted service users a week after their medical assessment in the sick bay and they are guided by the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2009). It is often during their assessment that, the service users are readmissions and have relapsed. Nazari et al (2016, p. 175) highlight that, in Iran, between 20% and 90% of substance users who have successfully completed rehabilitation treatment programmes end up relapsing. After it was found that, the service user is a readmission, the family would be contacted to find out what triggered the service user.

During the conversation, there were different emotions that, the significant others were experiencing. They were angry, confused, frustrated, anxious, fearful, worried, depressed and embarrassed as well as feeling guilty (Choate, 2016, p. 463). In many instances, these emotions felt and expressed by the significant others are caused by the behaviour of the service user. The significant others complained that the service user acts aggressively when the service user is the provider in the household and, owing to his addiction, he stops taking financial responsibility in the household and stops being a present father to their children and a present husband to his wife. The significant other feels burdened by having to carry all that needs to be done. At times when the significant other tries to express their thoughts or questions the service user about what the problem could be and how the significant other might be able to help,

this conversation leads to domestic abuse/violence. This may lead to separation of the service user and the significant other and the children will now also be in distress.

It was observed that, service users who are readmitted are more likely to relapse and be readmitted again than service users who are being admitted for the first time. For instance, the service user is facing a wife who wants a divorce and wants to take the children with her. The service user realises that he is going to lose both a family and the command he might have had as head of a household. He then begs the significant other, indicating that he is ready to change and to do things right. He vows to go back to the rehabilitation centre and promises to do things differently this time. The significant other eventually believes him and gives him another chance to get rehabilitated.

The service users who repeatedly relapse, four times or more, often terminate their treatment programme early or behave negatively during treatment. They are noncompliant and do not abide by the rules of the centre; for example, they sneak out at night to sell their toiletries to buy drugs; they often miss group and individual sessions; they bully service users that have been admitted to the rehabilitation centre for the first time; they are disrespectful towards staff members; and they want to do things their own way. This is more likely to put strain on institutional resources. This observation was further supported by Grahn, Chassler and Lundrgren (2014, p. 1765), who assert that service users who have relapsed were more likely to have a history of numerous treatment episodes than service user who remained abstinent after treatment and did not relapse. Mathew, Regmi and Lama (2018, p. 65) highlight that the family's morals, ethics and rituals modify the behaviours of the family member in terms of how to tackle the problem and the coping strategies affect the development of the individual.

The significant others ended up buying the drugs for the service users with the of hope of stopping them from stealing household assets, from the community or neighbours, or going to prison. They are unaware that they are encouraging the service user to keep on satisfying his addiction. This situation affects families that come from poor backgrounds, because they are not able to provide for their family members. Similarly,

Voskuil (2015, p. 4) indicates that the nation and the families of service users are suffering financially and psychologically because of service users, and a burden is placed on treatment facilities in terms of their capacity. This whole situation affects their family members emotionally, financially, and socially. Sometimes their family does not want them to come back home, and the social workers will find a place for them to stay. Sometimes the families do not understand the service users. When the service user is readmitted, social workers rely on the service user to know why they relapse repeatedly. The family is not involved. It is important to involve the families, because the behaviour of the service user also affects them. This study will explore the way families understand recurring relapses in substance use, according to their own world (perception) and to understand the experiences of these significant others and to see the situation from their point of view. This will assist in developing new policies and empower social workers to improve their way of doing things and their therapeutic services will be more productive. The literature reviews have focused on the experiences of the significant other. For example, Lander, Howsare and Byrne (2013) focused on understanding how substance abuse affects the family. Moreover, September and Beytell (2019) studied family members caring for their relatives who are comorbid and the situation in which they are experiencing this.

When reviewing the literature gaps were identified from literature because authors focus on child addiction but not the adult addicts who keep on relapsing. The focus of the study is the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. This significant other can be a mother, father, wife, husband or child. In this study the focus is not only on the significant others who are taking care of service user but also who are staying with the service user

As mentioned, the gap in literature on the phenomenon encouraged the researcher to conduct the study and indicates that there is a need to investigate this phenomenon further. The rationale for the research study will be to explore the perceptions of the significant others whose adult family members have recurring relapses. In this study when collecting the data, the aim is to gain more in-depth understanding of the

experiences of the significant others who are living with adult family member experiencing reoccurring relapse from substance misuse through the information that they provide.

1.2 THEORETICAL FRAMEWORK

This study was conducted as a qualitative paradigm which uses inductive analysis as the main technique. In an inductive analysis “the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (Bowen, 2006, p. 13). Therefore, the data was given guidance in terms of where to find suitable literature (Giske & Artinian, 2007, p. 70). Some authors assert that when the study adopts the qualitative approach “there is a need not to review any of the literature in the substantive area under study for fear of contaminating, constraining, inhibiting, stifling, or impeding the study’s analysation of codes emergent from the data” (Mills, Bonner & Francis, 2006, p. 30).

Although the review of literature prior to conducting the study may inform a new study, it may also inadvertently hinder the emergence of phenomena by creating an unwanted lens, which may lessen the value of conducting a qualitative study (Yin, 2011, p. 61). Any review of literature prior to conducting the study may “contaminate, constrain, inhibit, stifle, or impede the researcher’s analysis of codes emergent from the data” (Mills et al, 2006, p. 30). The aim is to enter the field of research with no preconceived ideas (Bainbridge, Whiteside & McCalman, 2013, p. 276). Hence, authors caution that qualitative researchers should avoid reading pertinent or comprehensive literature about the phenomenon being researched until data collection for the research has been completed (Yin, 2011, p. 62). However, the researcher does not dismiss the importance of reviewing literature; hence, the researcher engaged in an extensive literature review during the proposal stage to provide an introduction and a general overview of the phenomenon. Most importantly, this literature review enabled the researcher to identify gaps in relevant knowledge and to frame the research problem.

Based on the discussion above, a separate literature review chapter was not included. Instead, literature was used to confirm or contrast the findings in Chapter 3 in the form of a literature control.

The theoretical and conceptual framework explains the path of the research project and its basis, and it also makes research findings more meaningful. The systems theory is employed to guide in exploring the perceptions of the significant others about their interactions with their adult family member with recurring relapses and to discover where the issue lies in the family interaction (De Vos et al., 2011, p. 512).

Systems theory was relevant to the study because it guided the study in describing the perceptions of the significant others living with an adult family member who experiences recurring relapses in substance misuse This theory does not focus only on one person or on one family member but involves everyone in the family or every part of the person and their interaction. The recurrence of relapses in substance use is not only the problem of the service user in the family; it also affects the whole family, the community, and the whole country. Chikere and Nwoka (2015, p. 1) indicate that this will be helpful in guiding in the process of observing the significant others and taking into consideration all the things that are connected to them, including their internal and external world. This will bring change to the whole self of the significant others and their family.

Chikere and Nwoka (2015, p. 5) mention the following qualities of systems theory which are relevant to this study:

- **Components:** A component refers to anything that forms a part of a system or subsystem. This was employed in this study to guide process be able to focus on every section (wholeness) of the significant others, as mentioned above. This assisted in exploring and describing the perceptions of the significant others and also in listening to their experiences of the phenomenon. It guided in empathising with the significant others to understand their whole world internally and externally.
- **Connections:** The components of the system are related. This was employed in understanding the significant others and their relationship with the adult family

member who has recurring relapses, as connected to their environment and their surroundings.

- **Structure:** The concept structure and the organisation of this structure become more interesting in large systems where more than two structures were considered. The researcher focused on every structure that surrounds the service users, such as family, neighbours, and community. As indicated in the introduction, recurring relapses do not only affect the families, but also the rehabilitation centres and the nation itself.
- **Interactions:** The elements of this structure affect each other by their presence in or removal from the system, because of their mutual interaction within the system environment. The elements of the structure can affect each other either negatively or positively, for example, the interaction of the service users, the significant others, other family members, neighbours, and the community is bad. They are affected by the strange behaviour of the service users as they keep on relapsing and this affects the people around them negatively because they are stealing from them, and they cannot achieve their goals when they are still using drugs. With this behaviour they are hurting people around them and this causes strain in their relationships.
- **Process:** A change resulting from the interaction discussed above is called a process. Change will not only rely on the significant others, but also on their adult family member experiencing reoccurring relapses, and on their environment. When collecting the data, it was realised that it is not easy for the service users to stop using substance because it is like a vicious cycle: they go to rehabilitation centre; they stop using substance, some for a few weeks or some for months. The period of not using substance differs according to the service users: some used the same day that they were discharged from the rehabilitation centre.

  This changed the attitude of the significant other towards them, whereas the service users need support. The significant other, and other family members are hurt because they are discriminated against or judged by the community because of the behaviour of the service users. Changing the emotions of the significant

others, and of other family members towards the service users is also a process. Both the service users, the participants and other family member need skills and education on how to deal with the service users, and the service users need skills on how to cope without drugs.

- **Holism and emergent properties**: This guided focusing on the system, starting with the individual, then the community, and finally the nation. The substance use affects not only the health and the well-being of the service user but also of the participants, other family members, the neighbours, the community, the society and the rehabilitation centres.
- **Environment:** Environment is created by a person's actions and the behaviour accompanying their actions. The data was collected from the family members who know the history and background of the service user.
- **Identity:** From the data that was collected, similarities in the themes from the experiences of the participants were identified. This assisted in understanding how the participants perceive and understand the phenomenon in their own natural setting. This was used to support or disagree with the findings in Chapter 3.

These qualities of the systems theory guided the researcher in applying systems theory practically in the lives of the significant others, and of other family members and their community, whose adult family member has recurring relapses in substance use.

1.3 RESEARCH QUESTION, GOAL, AND OBJECTIVES

1.3.1 Research question

The research question is a statement about what the researcher hopes to have learned by the time they complete the research project (Kalu & Bwalya, 2017, p. 3). It is also an alternative to research objectives, where the key issues to be focused on in a research project is stated in the form of a question (Thomas & Hodges 2010, p. 39). According to Doody and Bailey (2016, p.19), the research question is an important step in a research study, as it shortens the research aim and objectives down to the exact areas on which the study will report.

The research question that needed to be answered by this study was formulated as follows: **What are the perceptions of the significant others living with an adult family member experiencing recurring relapses from substance misuse?**

1.3.2 Research goal

A research goal is generally defined as the target that the researcher plans to achieve (De Vos et al., 2011, p. 94). The goal of this study was to develop an in-depth understanding of the perceptions of significant others living with an adult family member experiencing recurring relapses from substance misuse.

1.3.3 Research objectives

Objectives are specific outcomes that contribute to and necessitate the attainment of the aim (Denicolo & Becker, 2017, p. 5).

The objectives of the study were formulated as follows:

- The researcher explored and identified the perceptions of the significant others living with an adult family member experiencing reoccurring relapse from substance misuse.
- The researcher described the perceptions of the significant others living with an adult family member experiencing reoccurring relapse from substance misuse.

1.4 ETHICAL CONSIDERATIONS

Ethics is a process or method procedure for deciding how to act and for analysing complex problems and issues (Gajjar,2013, p.8)The ethical issues that were considered and attended to in order to protect the rights of the participants during the process of this research project will be discussed in the following subsections.

1.4.1 Informed consent

According to Heggen and Guillemin (2012, p. 469), informed consent means that the participants are well informed concerning the purpose of the study prior to giving consent, and consent means a clear agreement to participate in the study.

Nijhawan, Janodia, Muddukrishna, Bairy, Udupa & Musmade (2013, p. 134) emphasise that, from the informed consent form, the participants will learn about anonymity and confidentiality. The elements central to the informed consent form include the following (Nijhawan et al., 2013, p. 134):

- A detailed explanation of the purpose of the study;
- An indication of the approximate period of time it will take to complete the study;
- A description of what participants will be asked to do;
- A description of any foreseeable risks or discomforts that may be encountered during data collection;
- A description of direct benefits to the participants;
- A statement of the extent to which confidential information of participants will be protected; and
- A statement of the voluntary nature of participation.

The above elements form part of the introductory letter (see Addendum A) and informed consent form (see Addendum B) that the researcher issued to participants prior to interviewing them. The concerned documents were translated for the participants into their own languages to ensure that they understood the information provided.

1.4.2 Confidentiality and privacy

Rubin and Babble (2016, p. 363) state that confidentiality means that the researcher can identify the participant, but that they will not do so in public. The information will not be passed on to others without the consent of the relevant participant. The confidentiality of the participants was preserved by not revealing their names or identities during data collection and analysis, or when reporting the study findings

(Lincoln, 2013, p. 153). The name of the participants will not be revealed to other people. Furthermore, Creswell (2014, p. 139) argues that some of the participants may not want to hide their identity, but they must still be well informed about the possible risks of non-confidentiality. To ensure confidentiality the name of the participant will not be revealed to the other people. The researcher will use letters that, she will be the only one who can identify their names. The interviews were conducted at Cullinan in the township known as Refilwe. It was their choice to be interviewed in the offices of Department of Social Development offices because privacy was ensured unlike in a public place or in their home where the privacy or information might be compromised.

To ensure privacy, the social worker was allocated an office where she was able to interview the participants. What was discussed between the researcher and the participants remained between them. Furthermore, the place where the participants were interviewed was private. (Masombuka, 2013, p. 24). However, the findings will be disseminated to the researcher's colleagues and to other relevant professionals with the intention of empowering them and getting feedback from the study. The researcher did ensure that what was discussed during the interview was kept confidential.

1.4.3 Anonymity

The ethical principle of anonymity generally refers to the protection of the identities of the participants who are prepared in participating in the research study (Goredema-Braid, 2010, p. 51). To ensure anonymity, the participants were protected from harm in order to build trust and raport amongst the researcher and the level of the study. (Masombuka, 2013, p. 24). This ensured that, their information will be protected especially in the process of giving the informed concerned. Pseudonyms were used and the participants' names or anything that could be used to identify them were not linked to their pseudonyms. The researcher is the only one who can link the pseudonyms to their real names. The supervisor had access to the information because he was guiding the researcher, however the information was identified by alphabet.

1.4.4 Management of information

Management of data is concerned with ensuring that the data collected is kept safe during the research process and beyond (Lin, 2009, p. 135). Safely managing the data saves the participants of the study from any form of physical or psychological harm, as the privacy and confidentiality are insured by putting all the collected data that might identify them in a safeguarded (Arifin, 2018, p. 32). To limit access to the data, the researcher created a password to the computer in which the collected data was saved.

1.4.5 Debriefing of participants

Debriefing sessions provide an opportunity for participants who might have experienced emotional pain during the research process or after the interview to work through that painful experience (De Vos et al., 2011, p. 122). The research process will sometimes evoke negative emotions in the participants. Therefore, it was the responsibility of the researcher to arrange with a qualified person such as a social worker to debrief the participants to ensure that the research study did not cause any adverse effects, or so that the participants can be referred to the appropriate services if they were negatively affected in any way (see Addendum F). During the process of the study there were participants who needed counselling. For example, Participants 5, 8, 12, 14, 15, and 17 were referred for debriefing. The participants were also informed during their first meeting that they can stop at any time if they are uncomfortable with the questions.

In 2015,7.9% of women and 12.5% of men aged 12 and older was reported that, they are misusing substance, and the dominant gender was male. Substance misuse is significantly more prevalent among men than women. The literature on sex and gender differences in treatment response is limited (Sex and gender differences in treatment centre,2019, p.6).

1.5 CLARIFICATION OF KEY CONCEPTS

The definitions of key concepts in this study are provided below, as well as an explanation on how they were used. It is important that these concepts are understood in the context of this study:

- An **adult** is any individual who has reached the age of 18 (Constitution of South Africa, 2006, section 17). In this study, the concept *adult* has a different meaning. It refers to a person who has reached 18 years of age but was identified as a child and they still need motivation and supervision to have a better future. Any family member who is older than that family member, because they are older they will address that younger family member as a child. For example, if a person is 50 years old, whether married or not married and having children or not, their mother will still treat them as a child.
- **Family** is society's primary institution for nurturing children, taking care of the elderly, and forwarding the values of that society to the children. It is a source of emotional support and comfort. It is the mediator between the individual and the nation, where individuals can learn and practise their culture. For these reasons, family is the most important long-term commitment beyond the self (SADC, 2010, p. 5). In this study, the concept *family* refers to the blood related relatives like the mother, father and their immediate children, the siblings, and extended family like nieces and nephews, aunts and uncles and grandparents.
- **Perception** is the unique way that an individual or group views a phenomenon involving the processing of stimuli and incorporating memories and experiences in the process of understanding (Macdonald 2011:15). In this study, perception refers to experiences that the researcher explored and described during the research process. The researcher did not impose her knowledge or her experience on the participants, but she allowed them to voice their understanding of the phenomenon, according to their experiences.
- **Relapse** refers to a behaviour of the person who wants to change his attitudes from being addicted to being sober; however, during the process of maintaining their sobriety, they decided to fall back into the habit of using again (Kabisa

Biracyaza, Habagusenga & Umubyeyi., 2021, p, 2). In this study, the concept *relapse* refers to the service users who were addicted to drugs and decided to go to a rehabilitation treatment centre to be assisted in living the sober life; however, when they went back into the community, they decided to use drugs again.

- **Significant others** include the supportive social network that can monitor the service user's stability of recovery, abstinence from drugs, and compliance with treatment (United Nations Office on Drugs and Crime, 2017, p. 60). In this study, the concept *significant others* were used to refer to any family member living with the adult family member experiencing reoccurring relapse from substance misuse.

1.6 STRUCTURE/FORMAT OF THE STUDY

The research report consists of four chapters, namely:

Chapter 1: General introduction and problem formulation

Chapter 2: Focus on the application of the qualitative research process.

Chapter 3: Focus on the research findings on the perception of significant others of family members who keep on relapsing.

Chapter 4: Focus on the conclusions and recommendations.

CHAPTER 2

APPLICATION OF THE QUALITATIVE RESEARCH PROCESS

2.1 INTRODUCTION

This chapter entails information on how the research methodology was applied in the study. The qualitative research process directed the study in exploring, describing and contextualising the perceptions of significant others about their adult family member's repeated relapses in substance abuse. The focus of the chapter is on applying the research approach, design, population and sampling in preparing the participants for data collection, the pilot study, data analysis and data verification.

2.2 RESEARCH METHODOLOGY

The researcher can choose between two approaches when conducting a study, namely the qualitative or the quantitative approach. Alternatively, these approaches can be combined, depending on the topic of the study or on how large the study is. The researcher decided to choose the qualitative approach because the researcher wanted to understand the meaning and the perceptions of the significant others according to their way of thinking about the phenomenon and their understanding of that phenomenon in their environment.

2.3 RESEARCH APPROACH

The research approach is a plan that includes the methods that will be utilised to collect, analyse, and interpret the data (Creswell, 2014, p. 3). Ehrlich and Joubert (2014, p. 39) highlight that the qualitative approach assists a researcher to understand how participants perceive their situation within their environment.

In this study, the researcher used a qualitative research approach. Qualitative research is described as a way of assisting the researcher to find the information from the analysis of data, rather than by applying her own knowledge (Ritchie, Lewis, Nicholls & Ormston 2013, p. 3). The qualitative research approach often includes words rather than numbers (Creswell, 2014, p. 3). This approach was carried out to enhance the researcher's exploration of an understanding of the participants' cultures, beliefs, and values, and their experiences about the situations they are in, as well as to develop theories that clarify these experiences. This approach assisted the researcher to identify the participants' feelings and what encouraged them to make a specific decision in the way they did (Kalu & Bwalya, 2017, p. 44).

In this study, the participants shared their understanding about their adult family member who has recurring relapses. Litchman (2010, p. 1565) describes the qualitative research approach as the way in which the researcher collects the data and interprets the information gained from the research participants using listening and observation skills. Qualitative research is based upon the need to understand individuals, their social interactions, and the way they relate to their own world (Kartch, 2017, p. 1074). Therefore, the perceptions of the participants are vital to the researcher's purpose in understanding their experiences to investigate the phenomenon under study.

The following characteristics, mentioned by Creswell (2014, p. 234), also encouraged the researcher to choose this method:

- **Natural setting**

Qualitative research does not seek to bring the participants to a lab. The researcher employs this approach to give access to conducting interviews of the participants in their natural setting where they are experiencing the problem. (Creswell, 2014, p. 185). Naturalistic settings allow for a deeper understanding of the phenomenon being studied and the development of contextually relevant findings (Kalu & Bwalya, 2017, p. 47). In this study, the researcher interviewed the participants in their own environment where

the participants felt comfortable and free to voice their opinions. This approach afforded the researcher an opportunity to observe the reactions of the participants' every time she posed a question to them. The researcher focused on their body language and facial expressions and listened to the tone of their voices.

- **Researcher as key instrument in data collection**

In qualitative research, the researcher is a significant tool in the process of data collection through interviews, observations, and the examination of documents (Creswell, 2014, p. 185). The qualitative research approach allowed the researcher to be involved from the beginning of the process until the termination thereof. The researcher collected the data on her own, not relying on others to conduct the interviews, and she used open-ended questions through semi-structured interviews, as instructed by the interview guide.

- **Inductive and deductive data analysis**

Qualitative research analyses data through an inductive process by which the researcher works continuously to identify the main themes until a comprehensive set of themes is established (Creswell, 2014, p. 186). The researcher analysed the identified themes that were generated during data collection. The main purpose of employing the qualitative approach is achieved as it was to identify themes that are generated during the data.

- **Participants' meanings**

The primary focus of the researcher in a qualitative research approach study is to obtain the participants' understanding about a phenomenon or about the problem being studied. The focus is not on expressing facts/opinions from literature or the researcher's own understanding (Creswell, 2014, p. 186; Maree, 2012, p. 731). In this study, the researcher employed this method so that it could guide her not only to rely on information gathered from literature, but also to listen to the experiences of the significant others with an adult family member who has recurring relapses.

The researcher used member checking to determine the accuracy of the qualitative findings by taking the final report or specific descriptions or themes back to participants and determining whether the participants felt that they are accurate. In this study, the researcher conducted a follow-up interview with the participants to discuss the interviews that were done during the research study. The researcher met with the participants individually because of COVID-19. During the first meeting with each of them, she read the interview guide to them and gave them a chance to seek clarity when they did not understand something. The researcher also considered the level of their education while she was reading and explained to them when they misunderstood some of the questions.

- **Reflexivity**

Reflexivity has to do with how the researcher's personal background, culture, and experiences can influence the interpretation and shaping of the study. However, it does not mean that the researcher should ignore their biasness; no researcher is required to articulate and reflect upon their "position and subjectivity" (Sutton & Austin, 2015, p. 226). The researcher appreciated her values, culture, experiences, and beliefs during the process of collecting and analysing the data in that she did not allowing them to influence her negatively towards the participants when they explained their perceptions, according to their frames of reference. The researcher accepted the participants unconditionally by not judging them. She respected the experiences and the understanding of the participants.

- **Holistic in nature**

Qualitative research endeavours to create a global picture of the issue or problem under study. It focuses on the many factors involved in the situation and reports on multiple viewpoints (Creswell, 2014, p. 186). The researcher's aim of exploring and describing the perceptions of the significant others and the way they understand the phenomenon in their own world was achieved. This was achieved by collecting the data and after that, identifying the themes and subthemes with the assistance of the independent coder and the supervisor.

2.3.1 Phenomenological approach

The researcher employed the **phenomenological approach**, as it is used to emphasise a person's experiences and their experiential action in their own world (Koopman, 2015, p. 6). The phenomenological research approach is based on the view that each person is unique and self-determined, and it yields the results of how people interpret their own world (Umanailo, 2019, p. 1). Phenomenological research design seeks to represent the whole world of the participants based on the in-depth exploration of their understanding about their experiences (Motsoeneng, 2018, p. 12). Phenomenological research is also used to explore the knowledge and the meaning of the experiences that the participants have about the particular phenomenon (Kalu & Bwalya, 2017, p. 47). The researcher employed this design because it focuses on the experiences of the participants regarding the phenomenon and their interpretations of that situation.

2.4 RESEARCH DESIGN

Research design is defined as a master plan for the determined methods, structure, and strategy of a research study to find alternative tools to solve the problems, and to minimise the variances (Mohajan, 2017, p. 66). The research design was employed to answer the formulated research questions. In this study, the researcher applied the following research designs: the exploratory research design, descriptive research design, contextual design, and phenomenological design.

2.4.1 Exploratory design

Reiter (2017, p. 144) highlights that the aim of **exploratory research design** is to apply new words, concepts, explanations, and theories to reality with the expectation of offering new ways of seeing and perceiving how this segment of reality works. The

researcher employed exploratory research to examine relevant factors in detail to arrive at an appropriate description of the reality of an existing situation (Creswell, 2014, p. 17). An exploratory research design is conducted when there are few or no earlier studies to refer to regarding the research problem. The focus is on gaining insights and familiarity for later investigation or for when problems are in a preliminary stage of investigation.

The researcher applied this research design, because little is known about the perceptions of significant others whose adult family members have recurring relapses. The researcher utilised this research design to gain new insights and to discover new ideas from the significant others to increase the available knowledge of the phenomenon and to combine these insights and ideas to create a new theory that develops directly from the data (Stebbins, 2011, p. 8). The researcher used face-to-face interviews to apply this design, which allowed her to interact with the participants and to explore their experiences in identifying their knowledge according to their own understanding about the topic (Radebe, 2015, p. 42). The researcher applied this design because the participants who were involved in the study have knowledge about the topic.

2.4.2 Descriptive design

The **descriptive research design** is defined as a method used to describe the existing phenomenon as accurately as possible and the aim of this research is to describe systematically the existing phenomenon under study (Atmowardoyo, 2018, p. 198). The descriptive design is relevant to this study because the researcher collected the available data using methods such as interviewing the participants and observing their behaviour during the interviews (Atmowardoyo, 2018, p. 198). The design was applied because one of the objectives of the study was to describe the perceptions of the significant others with an adult family member with recurring relapses. Bradshaw, Atkinsons and Doody (2017, p. 4) state that researchers may have to mask contextualisation to some extent to protect participants' identities, while still ensuring

that what is reported is verbatim or as near to the meaning literally described by the participants as possible.

2.4.3 Contextual design

The **contextual research design** is important in conducting qualitative research. Lambert and Lambert (2012, p. 255) indicate that qualitative descriptive studies are focused on natural settings or contexts, which encourage a commitment to studying the phenomenon in its own world to the extent that is possible within the context of the research study. This means the researcher will describe the context of the significant others whose adult family member has recurring relapses.

The researcher used the offices that are in the community of the participants as their natural setting to collect data. This is their natural setting because, they live in that township and they know each and everything that is happening around them. This made the participants feel comfortable and encouraged them to express their understanding about their family member who has recurring relapses. This was important to the researcher because she learned everything that is connected to them and observed how they reacted in their context. The researcher explained the biographical questions to the participants, because these questions indicated the context in which the data was collected.

The researcher developed a better description of the understanding of significant others of their context. As such, rich data were collected from the experiences of the significant others whose adult family member has recurring relapses. The researcher made recommendations based on the outcome of this study which investigated the experiences of the significant others whose adult family member has recurring relapses.

2.5 RESEARCH METHODS

Research methods are generally defined as the means by which the researcher collects, analyses, and interprets the data (Creswell, 2009, p. 184). To achieve the above-mentioned goal, the researcher identified the different themes in the data collected during the research study. This section presents a discussion of the research method which entails the research population, sampling, and sampling methods.

2.5.1 Population

Population is defined as the entire group of persons or research subjects that the researcher wants to study because it contains all the characteristics that are of interest to the researcher. Furthermore, Taherdoost (2016, p. 23) states that *population* refers to a number of individuals living in a certain place/environment. Chetty (2011, p. 32) defines population as all people, places, organisational units, and sampling units with which the phenomenon is concerned. Ehrlich and Joubert (2014, p. 98) advise that population should be clearly defined in respect of person, place, and time, as well as other factors of the study.

As such, population can be identified as a bigger group of individuals from which the participants who meet the criteria can be selected for data collection. For this study, the population comprises the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. The participants must reside in Gauteng under the municipality of Tshwane. Owing to the large nature of the population, it would be somewhat impossible for the researcher to study the whole community; hence, a sample was selected from the population (Ehrlich & Joubert 2014, p. 8). What follows are the description of the concept *sampling* and the sampling methods applied in this study.

2.5.2 Sampling

Sampling is the act of selecting a few individuals who are going to participate in research from a bigger group (Taherdoost 2016, p. 19). Emmel (2013, p. 138) states

that ᴛhere are no instructions to choose a sample size in a qualitative inquiry. Rather, sample size depends on whether new information is still emerging (Emmel, 2013, p. 147). Bradshaw et al. (2017, p. 1) indicate that, in qualitative research there is no fixed rule that focuses on the sample size; instead, facts should be considered. The researcher accepted the principle of data saturation as a requirement to determine the sample size within the qualitative design (Bradshaw et al., 2017, p. 4). Data saturation was an alarm to warn the researcher that no new information is emerging from participants when interviewing the eighth one; however, she continued until she had interviewed 17 participants.

2.5.3 Sampling method

The researcher employed both the non-probability and purposive sampling techniques. Hays and Singh (2011, p. 8) indicate that the intention of purposive sampling is to select participants who have more knowledge about the phenomenon, rather than simply choosing any participants who want to take part. The researcher purposively selected the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. These participants have more knowledge about reoccurring relapse of their adult family member who experiencing relapse. In this regard, the researcher's criteria of inclusion and exclusion in the study were as follows

Inclusion criteria

- The participants are significant others living with an adult family member experiencing reoccurring relapse from substance misuse.
- The participants should be able to understand and speak English, Sepedi, or Setswana. (Even though the interviews were not written in Sepedi or Setswana but the data was collected in their language. Before the interview the questions were discussed in their languages.

Exclusion criteria

- The sampling of the significant others who are not living with an adult family member who are not or experiencing reoccurring relapse from substance misuse.
- Provinces other than Gauteng were excluded.
- Those who could not understand and speak English, Sepedi or Setswana were excluded.

2.6 DATA COLLECTION

This section provides an outline of how the researcher and participants were prepared for data collection, as well as the methods that were utilised to collect data.

2.6.1 Preparation important for data collection

It is to choose the sample purposively so that the individuals who are selected have experience with the central phenomenon (Etikan, Musa & Alkassim, 2016, p. 2). It is valuable because it was guided in finding ways of making contact with the participants.

The researcher must prepare the environment to be conducive to eliminating any fears that the participants might have about the research project (Creswell, 2014, p. 132). (To make sure that the environment cannot put the life of the participants in danger (to be exposed) or at high risk to be infected by COVID 19, see the attached Addendum A)

Participants in this study are the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. The researcher obtained permission to conduct her study at the Dr Fabian and Florence Ribeiro Treatment Centre from the head office of the Department of Social Development (see Addendum E). After the researcher was granted permission, the case managers were informed about the research study and they were made aware that the researcher relied on them to get the contact numbers, names, and addresses of the significant others and service users who experienced recurring relapses.

The participants were contacted to find out whether they were interested in participating in the study. The researcher arranged a meeting with participants who were willing to participate with the intention of introducing them to the whole process. The pre-screening interview was done to protect the health of the participants and researcher (see the attached Addendum A). After the meeting, which was done individually (see attached Addendum A), the researcher gave them a consent form to sign, and this allowed the researcher to proceed with the collection of data (see Addendum B). The requirements for COVID-19 were followed (see attached Addendum A). In preparing the participants for the study, the following factors were taken into consideration:

- the purpose of the study;
- possible value of the study;
- the reason that participants were considered to participate in the study;
- the location where the interview took place;
- the duration of the interview;
- the list of questions to be included in the interview guide;
- the use of a tape recorder during the interview and the purpose thereof; and
- all ethical considerations.

2.6.2 Methods of data collection

In this process, because of COVID-19, there were some changes in terms of how data were collected to ensure the safety of the participants and the researcher (see the attached Addendum A). In this study, the researcher used a semi-structured interview. A semi-structured interview contains questions that are outlined in an interview guide with the intention of covering specific issues (Patton, 2014, p. 14). Semi-structured interviews collect information in the form of face-to-face interviews with the participants. (The explanation on how the participants would be protected is in the attached Addendum A). Olsen (2012, p. 2) indicates that research is more than collecting information or writing a description and analysing the information carefully before reporting on the results. The researcher made use of an interview guide to ensure that

the main questions of the study are covered. Open-ended questions allowed the participants to express their ideas and to share more details about their experiences.

2.6.2.1 Interview skills

Alshenqeeti (2014, p. 40) indicates that the researcher will use interviews as a method of collecting data. The purpose of the interviews is to gather information from the participants regarding their interpretation of the meanings of the described phenomenon. An interview is a conversation between the researcher and the participant, and its aim is to gather information from the participant with respect to an understanding of the meanings of the described phenomenon.

The researcher used the following skills during data collection:

- **Observation**:

This skill is divided into observation of participants and non-participants (Moffatt, 2015, p. 54). The researcher used this skill to collect data (Creswell, 2014, p. 15) by observing the participants' behaviour in their own environment, for example, the physical setup, the activities they are doing and their sequence as well as the results of the process and the emotions involved (Moffatt, 2015, p. 54) Creswell (2014, p. 241) highlights that, during observation, unusual characteristics of the participants can be noticed. During the interview, the researcher observed that some of the participants were not feeling happy about the behaviour of the service users. Their facial expressions indicated that they were angry about the situation.

- **Probing**:

This entails using follow-up questions that help the researcher to unearth the in-depth understanding of the participants (Goodman, 2011, p. 317). This skill allowed the researcher to probe and to expand on the participants' responses and, in so doing, to obtain rich information (Alshenqeeti, 2014, p. 39).

- **Active listening**:

This skill is an important technique in giving meaning to situations in which people express themselves and it goes beyond hearing what participants say about the phenomenon. It also involves taking note of their needs, emotions, and verbal and non-verbal communication. The researcher made use of an interview guide to ensure that the main questions of the study were covered. Open-ended questions were used, which allowed the participants to express their ideas and to share more details about their experiences. The interview guide directed the interviews to ensure that they were on the right track and that the relevant themes were explored. The purpose of the interviews is to gather information from the participants regarding their interpretation of the meanings of the described phenomenon.

2.6.3 Pilot study

A pilot study may be a small study to test whether the larger study (project) will work out. Chetty (2012, p. 33) indicates that it is important to do requisitioning in order to test whether the questions will work properly in the real study. Furthermore, Van Zyl (2017, p. 53) indicates that “pilot studies are conducted within a smaller group than the actual group, study group, within individuals that possess the same characteristics as the actual participants” Moreover, Masombuka (2013, p. 16) defines a pilot study as a small version of the proposed study, with a restricted sample of subjects.

This will ensure that mistakes can be corrected immediately without cost (Chetty, 2012, p. 33). A pilot study can also be a pretesting or trying out of a research instrument. (Masombuka, 2013, p. 16) and it can be used to detect possible flaws in the measurement procedure, to identify unclear or ambiguously formulated items, and giving the researcher the opportunity to notice the non-verbal behaviour of the participants (Swanepoel, 2014, p. 47).

A pilot study is a test-run of the details of the main study (Ehrlich & Joubert, 2014, p. 9). The pilot study requires an in-depth look at the questionnaire with the aim of improving

its quality. The purpose of a pilot study is to determine whether the relevant data can be obtained from the participants (Royse, in De Vos et al., 2011, p. 395). Since the intention of the pilot study is not to produce results, the pilot data were excluded from the main study to avoid contradiction. Pilot studies are useful because they assist the researcher in making changes where necessary and revising how to achieve the goals of the research study (Kim, 2010, p, 199). The researcher recruited two participants from the population and conducted a pilot study with the intention of identifying any issues in the proposed study. The process enabled the researcher to revisit the interview guide and to make necessary changes.

2.6.3.1 The purpose of a pilot study

The importance of a pilot study is to serve its own purpose in the research study. Neuman (2011, p. 312) indicates that the "purpose of [a] pilot study in qualitative research approach is to test the nature of the interview questions and to determine if the responses gained from the questions are sufficient". The other purpose of a pilot study is to improve the reliability of the research project (Chetty, 2012, p. 33). In this study, the researcher recruited two participants from the population and conducted a pilot study with them with the intention of identifying issues of the study. The process enabled the researcher to revisit the interview guide and make necessary changes.

2.6.3.2 The process of the pilot study

The pilot study was administered on two participants who met the inclusion criteria of the research project. They did not form part of the actual study because their interviews were used to determine whether questions should be adjusted or rephrased. The participants were recruited through the files of the inpatient Treatment Centre. In this study, the informed consent form, which explained the whole process of the pilot study from the beginning to the end, was issued during the first meeting with the participants.

The purpose of the study, the time that the interview would take with them, and the types of ethical considerations were also explained to them. After all the information

was discussed with them, the researcher asked for agreement to recording them by giving them the form to sign, which they did. (See Addenda A, B and F) The participants were also given an opportunity to go for debriefing.

2.6.3.3 The outcome of the pilot study

Through a pilot study, the researcher was able to get an opportunity to change/rectify where necessary and to develop how to prepare the questioning. The researcher used the follow-up questions related to the responses of the participants. Based on the feedback of the participants and the help of the supervisor, the questions of the research project were modified accordingly. Some of the questions were repositioned, for example, the question at bullet 4 in section 1.a was removed to form part of the questions relating to topics at bullet 4. The question is: How was your reaction towards him/her after realising that she/he had relapsed? Prompts: this question will assist the researcher to know about the emotions and behaviour of the significant other after realising that his/her family member went back to the previous behaviour of using drugs.

The modification was also done at bullet 10 in section 2.b of the interview guide. It asked the participants how they are coping with the situation of the family member who keeps on relapsing. The researcher did give the participants the questions before the real interview so that they could prepare themselves before the interview. In section 2b, the new question seeking clarity was for included. How long did he/she stay sober before he/ she relapsed*?* (Prompts*:* focusing on the period before going back to drugs) The questions were rearranged because to ensure the logical and simple interview questions which are easily understandable*.*

The participants were having difficulty in expressing their feelings (emotions) during the interview. It is not easy for the participants to identify emotions in the African language, which forced the researcher to use leading questions, and this can be avoided by clarifying everything before the interview, as mentioned above. The researcher gave an example like: Are you feeling sad? Happy? How are you feeling? Then they responded

to the questions. The two participants in the pilot study were both related to adult family members who keep on relapsing.

The initial interview guide(s):

The initial interview guide was presented as follows:

Interview guide (s)

Section 1: Biographical questions for biographical profile.

- How old are you?
- What is your marital status?
- What level of education have you obtained?
- How are you related to the adult family member who repeatedly relapses?
- When did he/she get admitted into the rehabilitation centre?
- How many times did he/she get admitted?
- Did he/she ever get intervention for assistance?

Section 2: Topic-related questions/statements for significant others

- Tell me more about the recurring relapses of your family member.
- Please explain how these recurring relapses of your family member make you feel.
- What is your view and experience about the recurring relapses of your family member?
- Please share with me the challenges you are experiencing regarding the repeated relapses of your adult family member.
- What do you think encourages (motivates) him/her to continue with this behaviour?
- Please share with me the challenges you are experiencing regarding the repeated relapses of your adult family member.

It was noticed from the initial interview guide(s) that some questions were leading and some were incomprehensible to the participants. Such questions were adjusted,

rephrased, or removed, where necessary. In particular, the information on the revised questions and adjustment to the interview guide are presented below:

Section 1. b. Biographical profiling questions:

The biographical questions are divided into the following:

Participant

- How old are you?
- What is your marital status?
- What level of education have you obtained?
- How are you related to the family member who relapses?

Family member who relapses.

- Age
- Gender
- How long has your family member been into drugs?
- How many times did he/she get admitted? /relapsed
- Education

Section 2.b Topic-related questions

The final version of the interview guide was formulated as follows:

- Share with me about the recurring relapses of your family member (Prompts: When did she/he start using drugs? Which drugs? How did you realise that the person was using drugs?) Share with me your initial reaction when you realised that the person was using drugs.
    - What is your view and experience about the recurring relapses of your family member? *(*Prompts: How it affects the person, what do you think encourages him/her to continue with his behaviour? Identify things that the significant other identifies as the cause of several relapsing*).*
    - How was your reaction towards him/her after realising that she/he had relapsed? *(*Prompts: Emotions and behaviour towards the service user – the researcher

will probe to find out the emotions and the behaviour that the significant others exposed to the service user after knowing about his/her relapse*).*

- How long did he/she stay sober before he/ she relapsed*? (*Prompts: focusing on the period before going back to drugs)
- Why does he/she keep on relapsing? *(*Prompts: trying to find out if the family member has some time with the service user to try to find out from him/her the reasons for keeping on relapsing, try to find out what bothers him/her, how can they assist(support) him/her to maintain his/ her sobriety and also try to find out if they are not failing him/her.
- What role did you or any other family member play in assisting your family member who keeps on relapsing? (Prompts: the researcher wants to know what kind of support the significant other gave to her/his family member)
- Based on experience, what things would you like to change regarding the inpatient treatment programme to prevent the recurring of relapses? (Prompts: to identify things that the significant others are not happy about regarding the treatment programme. What are the new things they want them to be implemented to stop recurring of relapse?)
- Please share with me the challenges you are experiencing regarding the repeated relapses of your adult family member. (Prompts*:* Explaining their experiences (Telling their story – the researcher will probe to find the experiences of the family in detail about the recurring relapses).
- How are you coping with the whole situation? (Prompts: What did you do before that failed? What are you doing currently to make sure that you will succeed and what did you do before that succeeded?).
- How would you like a social worker to assist individuals who relapse? (Prompts: focusing on intervention strategies).
- How would you like social workers to support/assist families of individuals who relapse?

-

2.6.4 Method of data analysis

Qualitative data analysis involves taking apart the data, as well as putting it back together. Analysing data involves searching for designs in the information collected and the ideas that provide meaning to those designs (Bernard, Wutich & Ryan, 2010, p. 10). This enables the researcher to explore data in depth, while at the same time maintaining an effective and clear review path and enhancing the rigour of the analytical process (Smith & Firth, 2011, p. 53). The researcher used data analysis to collect the data and to specify the steps in analysing the various forms of qualitative data (Creswell, 2014, p. 245):

- The researcher transcribed the interviews which were digitally recorded. Once the researcher had completed this, she read all the transcriptions carefully to make notes of ideas as they came to mind.
- The researcher continued by selecting the most interesting or the shortest transcription and went through it. During the process of reading the transcription of an interview, she found the underlying meaning and she wrote down her thoughts in the margin.
- After completing this task for several transcriptions, the researcher made a list of all the topics and put similar ones together. The topics were grouped into ‘major topics’, ‘unique topics’ and ‘left-over topics’.
- The researcher found a fitting abbreviation (code, tag, or label) for each of the identified topics.
- The researcher found the most descriptive wording for her topics and turned them into themes or categories.
- The researcher made a final decision about the abbreviation for each theme or category and alphabetised them.
- The researcher used the cut-and-paste method to assemble the data belonging to each theme/category in one place and to conduct a preliminary analysis.

2.6.5 Methods of data verification

Data verification is an activity designed to determine whether the findings of the qualitative researcher are accurate. All research is subjected to rigour to ensure that findings are honourable (Bulpit & Martin, 2010, p. 7). Anney (2014, p. 272) argues that the issue of trustworthiness speaks to the quality of the study. To ensure credibility, the researcher included participants who met the inclusion criteria, namely the significant others whose adult family member have recurring relapses. Lietz and Zayas (2010, p. 443) suggest that, for a qualitative study to be recommended as a rigorous study, it must accomplish trustworthiness by focusing on the perceptions of the research participants.

The criteria for evaluating a qualitative inquiry are credibility, dependability, transferability, and confirmability. These are the four components to ensure the trustworthiness of qualitative studies. Trustworthiness is a valuable concept, since it allows the researcher to give quality explanations about qualitative terms that are usually used in quantitative research. These criteria for evaluating a qualitative inquiry were used to ensure trustworthiness, as recommended by Lietz and Zayas (2010, p. 191):

2.6.5.1 Credibility

Credibility involves the strategies that are used to manage the risk of being biased when representing the findings. Lietz and Zayas (2010, p. 192) state that credibility will depend on how researchers conduct themselves when the participants are discussing their experiences. The researcher may also be aware of possible research bias and the impact that the study methods might have on the participants. The researcher ensured credibility by utilising different techniques and skills when interviewing the participants.

Credibility is the development of early familiarity with the culture of the participants before data collection. This will occur during the process when the researcher builds trust between herself and the participants.

2.6.5.2 Triangulation

Triangulation involves the use of different sources and approaches to improve the richness and thickness of the research findings (Babbie, 2014, p. 121) by including interviews, observations, and document analysis (Creswell, 2014, p. 258). The researcher used different sources of information to ensure clear explanation of the themes. The process discussed below will add to the validity of the study.

First, the researcher used a rich, thick description to convey the findings. To ensure the richness and the thickness of the findings, the researcher took note of non-verbal expressions and body language during the interviews, as this adds meaning to the research study.

Second, the researcher used peer debriefing to enhance the accuracy of the interviews. This process involved the researcher's supervisor, who reviewed the collected data and made valuable comments. To ensure validity, the researcher submitted each transcribed interview to the supervisor for editing and comments. After the process was completed, the supervisor and the researcher had a discussion about the results. This allowed the researcher to grow, as she was able to see what had gone wrong, and this added validity to the research study.

Third, triangulation was employed to this study so that the study can be submitted to external lecturers to assess the whole research project and to comment on it.

2.6.5.3 Transferability

Transferability focuses on how relevant the research study is or whether the research findings will be useful to future research, theories, and practice (Lietz & Zayas, 2010, p. 195).

This means that the findings will be assessed to see whether they can be useful to future researchers, theories, and practice. The findings of qualitative research will be transferred to other places and environments with other participants (Anney, 2014, p.

277). To ensure transferability, the researcher will transfer the findings to her colleagues and relevant institutions to form new policies. This will enhance the capacity of her colleagues to render productive services.

2.6.5.4 Dependability

Dependability denotes that the study's findings are reliable and can be repeated. It involves the participants' evaluation of the findings and confirmation that the transcripts and the interpretation of those transcripts are a true reflection of what was said during the interviews (Rubin & Babbie, 2016, p. 634). To ensure the principle of dependability, the researcher makes use of transcripts and keep notes of all decisions made during the process. During the research process, the researcher followed the research methodology and made notes of all the consultations with her supervisor. Dependability was ensured by sending the transcripts to an independent coder to make sure that the data concurs with the findings.

2.6.5.5 Conformability

Conformability is the steps that need to be followed during the findings to ensure that the experiences and idea are of the participants, (Lietz & Zayas, 2010, p. 197). Furthermore, Kalu and Bwalya (2017, p. 51) To ensure confirmability, the researcher noted each and every step that was taken during the process of this study. There are several strategies that a researcher used to increase a study's confirmability, for example: the benefits of member checking, peer debriefing, and audit trails (Lietz & Zayas, 2010, p. 197).

2.7 CONCLUSION

This chapter gave detailed information about the application of the qualitative research methodology adopted in this study. The research design, research methods and methodology, data collection, analysis, verifications were discussed. Chapter 3 will

present the outcome of the application of the qualitative approach on the perception of the significant others whose family members have recurring relapses.

CHAPTER 3

RESEARCH FINDINGS OF THE PERCEPTIONS OF THE SIGNIFICANT OTHERS LIVING WITH ADULT FAMILY MEMBER EXPERIENCING REOCCURRING RELAPSES IN SUBSTANCE MISUSE

3.1 INTRODUCTION

This chapter presents a discussion of the research findings on the perceptions of the significant others living with adult family member experiencing relapses in substance misuse. The researcher compared the 17 themes of the participants with literature. The researcher used data analysis to compile the different views of information she got from the participants for her research study (Creswell, 2014, p. 245).

First, the biographical profile intends to personalise the characteristics of the significant others and the service users. Table 1 indicates the demographic characteristics of the participants and the service users that are suitable for this study. It includes gender, age, race, educational level, occupation, the duration that the service users have been on drugs, and the times that the service users keep on relapsing.

During data analysis, the independent coder and the supervisor were consulted and in the writing of the report it was agreed to eight themes and 23 subthemes to provide credible findings. The themes and subthemes emerged from the analysis. These themes and subthemes are included in Table 1 Demographic profiling of participants and affected relatives.

Table 1: Biographical data of the participants and their significant others

Participants					**Relationship**	**Affected relatives**			
P	Gender	Age	M/S	Highest level of education		Age	Highest Education	Period of drug abuse in years	Number of admissions
1	F	26	S	Grade 11	Brother	32	Grade 7	2 years	4
2	F	55	M	National Diploma	Son	21	Grade 11	4 years	2
3	M	45	M	Degree	Brother	38	Grade 9	15 years	3
4	F	63	S	Grade 8	Son	25	Grade 6	11 years	1
5	F	60	W	Grade 8	Son	26	Grade 9	1 years	1
6	M	43	M	Diploma	Brother	31	Grade 10	10 years	2
7	F	54	S	Grade 8	Son	36	Grade 7	16 years	1
8	F	62	S	Grade 8	Son	39	Grade 12	7 years	1
9	F	29	S	Degree	Brother	37	Grade 11	11 years	4
10	F	64	D	Grade 7	Son	22	Grade 5	5 years	4

Participants					Relationship	Affected relatives			
11	M	37	M	Degree	Brother	21	Grade 10	5 years	3
12	F	46	M	Senior Certificate	Nephew	23	Grade 11	3 years	4
13	F	48	M	Grade 11	Son	29	Grade 12	2 years	1
14	F	64	D	Grade 7	Son	22	Grade 10	1 year	3
15	F	67	M	Grade 8	Grandson	21	Grade 8	4 years	2
16	F	36	S	Certificate	Brother	23	Grade 9	5 years	1
17	F	57	S	Grade 7	Grandson	20	Grade 8	5 years	1

Keys=Participant; D = divorced; M = married; S = single, W = widow(er); M/S=Marital Status

3.2.1 Gender of participants and affected relatives

Fourteen women and three men participated in the study. It may be assumed that females are more involved in the life of the service users than males. All services users were males. Authors have similarly contended that males are at a higher risk of engaging in substance use (Schultz & Alpaslan, 2016, p. 90). Moreover, it was highlighted that addiction is noticed more among males than females (Casker, 2019, p. 19). Female addicts are different from male addicts. They suffer more severely from emotional and physical consequences from society. Thus, most of the time females experience difficulties in going to treatment; because of the stigma and fear, they do not come forward (Shiraly &Taghva, 2018, p. 89).

3.2.2 Age and relationship of participants and affected relatives

This study included different ages of the participants from youths to adults, and elderly people. The ages ranged from 26–37, 45–55, and 60–67. Age is a social representation differentiating the stages of human beings according to their task.

According to National youth policy (2020 -2030, p.2) indicated that youths are individuals between the ages of 15 to 35. Youths are not able to take care of their siblings who are service users. At this age their brains are developing and creating plenty of opportunities for learning and development (Mahans, 2020, p. 13933). Taking care of their brothers affects them emotionally and socially during the process of growing up. This overwhelming situation denies them a chance of developing natural and meaningful relationships within the family and the community (Schultz & Alpaslan, 2016, p. 90)

The elderly participants who can be the mothers and grandparents of the service users also have their own role in the life of the service users. They provide stability, security, guidance, and support for them (Zeng & Tan, 2019:2). They have a special relationship with the service users; hence, grandparents can be such powerful resources in helping the service users to stop from relapsing because they have special hearts and minds for their grandchildren (Zeng & Tan, 2019, p. 2).

In this study, most of the affected relatives are youths. Their ages range from 20 to 32 years. Drug addiction among the youth is different from that of adults. The youth do not have knowledge about the negative effects of the drugs on their future (Choate, 2015, p. 463). The service users started drugs during their adolescent stage as a result of the developmental process and this lasts until the person is in their mid to late 30s (United Nations Office on Drugs and Crime, 2018, p. 28). From this age, the service user should grab opportunities, creativity, innovation, talents, and energy for a better future but sadly, such opportunities will remain completely unharnessed because of drug addiction (Casker, 2019, p. 19). According to Sedibe and Hendricks (2019, p. 31), most youth start using drugs at an early age because of the following different reasons: they are often persuaded by their friends to do so, owing to failing relationships; they use drugs to cope with their education and deal with their feelings of failure.

3.2.3 Education and occupation of participants and affected relatives

Education is one of the most important necessities of life. An individual is incomplete without it because, through it, people learn how to think, how to work properly, how to make decisions, and it leads them to a successful and meaningful life (Bano, 2015, p. 48). Moreover, education does not mean having degrees with book knowledge, but it means having practical knowledge with one’s own sensibilities (Bano, 2015, p. 48). The participants achieved diverse levels of education: five participants had Grade 8; three had Grade 7, three had Grade 11, two had National Diplomas; three had university degrees.

The participants mentioned the different levels of education of the service users. Only two service users had passed Grade twelve, 15 had less than matric: The academic performance of service users is deteriorating when they are addicted to drugs; they are

unable to concentrate and they are unable to read and write the work off the board (Sedibe & Hendricks, 2019, p. 34). Lack of skills and knowledge on how to protect the service user from using drugs have increased the problem. Moreover, lack of access to education, high levels of unemployment, overcrowding and poverty as well as lack of economic opportunities can also contribute to negative behaviour (Likisa, 2019, p. 36).

3.2.4 Period of drug abuse in years and number of admissions

Relapse is common among service users who have received treatment for drug addict problems and very few service users remain abstinent in the year following treatment (Doerfler, Melle, McLaughlin, Fisher,2016, p. 516). Service users stayed sober for different periods before they relapse. Eleven service users have been using drugs for five years and less, whereas six service users have been using drugs for more than 10 years. The period time that some service users keep using drugs is because addiction is a chronic relapsing desease which forces service users to keep on seeking drugs (Leong, Jali & Jamil, 2022, p. 592).

When the service users first started using drugs they thought that it had positive effects and that they could control it but drugs took over their lives and then they are using it just to feel normal (National Institute on Drug Abuse, 2013, p. 4). That is why it is not easy for them to quit drugs. Hence, readmissions indicate a major relapse ‘crisis’ for the service users when they return to the rehabilitation treatment centre (Doefler et al, 2016, p. 520). The service users in this study relapsed several times, which made them go back to the rehabilitation centre: four service users were readmitted four times; three service users twice; three service users were readmitted three times; and seven service users were admitted only once.

3.3 DISCUSSION OF FINDINGS AND LITERATURE CONTROL

The researcher collected the data then with the help of the independent coder and supervisor they put the similarities together and that is the reason where themes and subthemes emerged.

The subsequent section presents the themes and subthemes described in Table 2, providing verbatim quotations from the transcribed interviews, subjected to literature control.

Table 2: Themes and subthemes

Themes	Subthemes
1. Participants' understanding of the causes of their relatives' recurrent relapses	1.1. Participants suspected the cause to be the absence of parents 1.2. The family view their relative as lacking direction, motivation, and a goal. 1.3. Participants feel that their relative need divine intervention 1.4. Relatives use drugs owing to boredom and unemployment. 1.5. Users are always in the company of friends who are using drugs as well – peer pressure
2. Participants' feelings and reactions after discovering that their relatives continued to use drugs	2.1. Participants' feel pain and hurt about their relatives' drug use 2.2 Anger and disappointment 2.3. Painful and stressful
3. Effects of drugs on the users' physical, mental, and social well-being	3.1. Effects on the users 's physical well-being 3.2. Effects on the user's mental health 3.3. Effects on the user's interpersonal relationships 3.4. The users engage in criminal behaviour to feed their addiction
4. Effects of relatives' use of drugs on the family's well-being	4:1. Effects on family's well-being 4.2. Strained family relations

Themes	Subthemes
5.Effort by participant and the family to assist relatives who are relapsing	5.1. Participants' efforts to assist their relative who is relapsing 5.2. Family efforts to assist relatives who are relapsing 5.3. User's efforts to deal with the addiction
6.Participants' coping mechanisms	
7.Participants' suggestions on the improvement of inpatient treatment programme	7.1. Extension of service users' period of stay in the rehabilitation centre to develop skills 7.2. Inpatient treatment centres should eradicate the self-discharge policy 7.3. Inpatient treatment centres should improve security and services 7.4. Inpatient centres should offer better services.
8.Suggestions for social work services	8.1. Services required by relatives with recurring relapses 8.2. Services needed by participants

3.3.1 Theme 1: Participants' understanding of the causes of their relatives' recurring relapses.

The understanding of the participants about the causes of the service users' recurring relapses will be presented under this theme. The following subthemes will be discussed: Participants suspected the cause to be the absence of the parents; the family view their relative as lacking direction, motivation, and goals; participants feel that their relative needs divine intervention; relatives use drugs owing to boredom and being unemployed; and users are always in the company of friends who are using drugs, as well as peer pressure.

3.3.1.1 Subtheme 1.1: Participants suspected the cause to be the absence of parents

The absence of the father has a negative impact on the development or the life of their sons. In the process of raising the sons, the father protects them in unsafe places such

as where they are using or selling drugs and they can also give their sons guidelines about not using drugs (Yogman, Garfield, Bauer, Gambon, Lavin, Lemmon, Mattson, Rafferty & Wisson, 2016, p. 5). In the absence of the father, it is dangerous because their sons can get guidelines from their peers or from the wrong people, which may contribute to the use of drugs as well as to relapsing. On the other hand, sons whose fathers are involved in their life have been shown to be less likely to start using drugs.

Unsurprisingly, some participants did see the important of the fathers in the lives of their sons. They believe that if the fathers raised their sons, they will have managed to maintain their sobriety. This assertion was expressed in the following extract:

> [He did grow up without a father and currently his father is back in the house, but he is not giving him any support. Even if he can ask his father for something, he will not give it to him, this thing gives him stress] (P10, F, 64years)

The findings seem to support the assertion that the father's support is important in raising their sons and it has a positive outcome in the life of the son (Shahzad, Abdullar, Fatima, Riaz & Mehmood 2016, p. 227). However, if the father is not giving him support, the possibility is high that the son will relapse. Furthermore, this lack of support from the father can be seen in a lack of participation or interest in the son's life, financially, emotionally, educationally, and in not encouraging the son to do the right thing (Shahzad et al., 2016, p. 229). Similarly, other authors contend that the involvement of the father in the life of their sons who keep on relapsing is important because it reduces behavioural problems. (Yogman et al., 2016:2).

The death of the father has also a negative impact on the children's adulthood outcomes (Kailaheimo & Erola, 2020:434), as was reflected in the extracts below:

> [I do not know, maybe he thinks too much about the death of his father] (P4, F,63 years)

> [I do not know, maybe it his father's death. I do not know, but I do not believe so because it is long since he passed on. It was in 1997.It is a long time. He was alright all these years. But the other day he told me that, he got the drugs from his friends that he is spending time with them*]* (P5, F, 60 years)

> [He is not bothering us, but we want him to stop using drugs. His behaviour of using drugs affects us emotionally but there is nothing that I can do. Because his father died in 2006 there is nothing that I can do.] (P4, F, 63 years)

The high level of father's support is crucial within families because it adds unique contributions to the life of their sons, when mothers are unable to provide such support (Whitney, Prewett, Wang & Chen, 2017, p. 103). Hence, one participant believes that, if the fathers of their sons where present in their lives, they would not be experiencing the problems that they are currently facing. This view was captured in the following extract:

> [To tell the truth, the person is not my biological son but my sister's son. Since her mother passed on while he was still young, I raised him with care and love. He just discovered that I am not his mother. I was taking good care of him, if maybe I was not taking a good care of him or maybe outside people told him that I am not his mother, and this may have affected him somehow.] (P8, F, 62 years)

Similarly, authors concede that the death of a father can cause a traumatic experience in the life of the service user, and this can weaken their decision making (Kailaheimo & Erola, 2020, p. 436). The participants see the importance of fathers in the lives of their sons. This is explained by the recent meta-analysis of longitudinal studies which say that fathers' involvement in the life of their sons is associated with increased cognitive development in the sons and decreased behavioural problems, delinquency and economic disadvantages in families or low socioeconomic status (Yogman et al., 2016, p. 5). It also increases social responsiveness, independence, and gender role development through the involvement of the father giving them support and guidelines.

3.3.1.2 Subtheme 1.2: The participants view their relative as lacking direction, motivation, and goals

Substance use has destroyed the future of many people (Burwell, 2016, p. 1). It is, therefore, important for the users to have direction because it develops growth and maturity in their life. Three participants considered their relative not having goals, direction, and motivation because they are not focused, and this makes them not be able to stop using drugs. They also believe that the community structure affected the service user to relapse because there are no activities with which they can entertain themselves. This assertion is explained by the extracts below:

> [My view is that the person who is using nyaope does not have a direction, goal motivation, job….] (P12, F,46 years)
>
> [He lacks motivation, just living for drugs.] (P2, M,55 years)

The extracts above regard goals to be important in the life of the service user because they believe that it is a process of establishing their direction in future and it can also motivate them to stop using the drugs (Dotson, 2016, p. 44). Motivation is a process of helping the individual to achieve their goal to satisfy their needs (Haque, Haque & Islam, 2014, p. 62).

Moreover, the participants believe that motivation is an important component of relapse prevention. Similarly, authors contend that service users relapse because they are not motivated and they also believe that lack of motivation or readiness to change is a barrier to the service user as they cannot stop the drugs (Doerfler al., 2016, p. 520).

However, Sarpavaara (2014, p. 100) cautions that it is important for the participants to understand that motivation for change does not always mean that the service users can be motivated to stop using drugs, but that they can decide to continue using drugs.

One participant was of the view that lack of facilities in the community encourage the service user to continue using drugs because they are bored and on top of that they are unemployed. This was expressed in the scene below:

> [Lack of motivation, loss of direction somehow, and lack of community structure meaning the community is lacking lack of activities like sports and indigenous games that will keep people busy. The settings in the community are not encouraging people who are not educated to take education seriously. You go to the community, and you find people who have diploma/degrees still roaming around not having a job. This encouraged them to associate with their peers because they are bored, then they started using drugs. There is no structure which is encouraging the youth to strive towards their goal.] *(*P2, M 55 years)

Similarly, the findings support the assertion that, in instances where community structure does not have activities such as sports facilities, or cinemas where the service users can entertain themselves, users are more likely to relapse (Swanepoel, 2014, p. 1). They see the setting of their community as not encouraging the service users who are not attending school because people who have diploma/degrees are roaming

around without jobs. This situation encouraged them to stay in groups and they encourage and support each other in the continued use of drugs (Motsoeneng, 2018, p. 43).

3.3.1.3 Subtheme 1.3: Participants feel that their relative needs divine intervention

Religion is an organised system of beliefs that are established in rituals, values and guidelines and it gives goals and a meaningful life (Doerfler et al, 2016, p. 250). According to the Christian religion, only God has the power to destroy the evil spirit from the service user because it is seen as if the demon is playing tricks (Giordan & Possamai, 2016, p. 449). In Christianity and Islam, it is believed that possession is a negative religion or spirit; they see this possessing spirit as demonic (Giordan & Possamai, 2016, p. 449)

Some Christians believe that the service users are controlled (Giordan & Possamai, 2016, p. 448). One participant believes that the service user is possessed by the demon and that is why he is unable to stop using drugs. The extract below explains that

> [I do not know this thing of using drugs, I will say it is a demon. If they do not have any monitoring and supervision from their significant other on how to manage their money, whatever money they are getting they buy drugs and they do not even eat well.] (P6, M,46 years)

Prayer is an activity related to spirituality and religion (Simao, Caldeira & de Carvalho, 2016, p. 1). It can assist in solving problems that are bothering the service users because it is helpful in creating a sense of hope peace, and self-actualisation and it makes the service user feel that he is next to God (Nooripour, Tavalaei, Hosseinian, Alikhani, Zademohammadi & Pourebrahim, 2016, p. 10). Therefore, the participants in the extracts below believe in the power of prayer to help service users with their addiction:

> [I am always praying on his behalf. In prisons there are a lot of bad things happening. There are different types of gangsters, for example Satanism. I have seen a man on TV talking about that he had joined Satanism and left it because he decided to believe in God. He is succeeded in life and decided to write a book about his history. I trust God, even you my child, [referring to the researcher] in your life you must trust God.

> Everything that you need you must communicate with Him. I believe that one day this child will be a man]. (P10, F, 64 years)
>
> [Remember these people who are using drugs, including my younger brother, do have regrets in their lives. They have experiencing bad things that we as their family members are not aware about what is bothering them. After he has used drugs, he will sit on the chair, and you will see from his facial expression that this guy is very tired. It normally happens when he has money because he has more skills, he fixes cars, he does a lot of things. Sometimes you are not feeling comfortable when people need assistance from him because after paying him, he will use the money to buy drugs. And after you can see that, he is regretting, he will promise to change. Hey, I am trying to leave this; hey, please pray for me. It is so touching to see him in this situation] (P6, M,46 years)

The story lines seem to suggest that drug users may need prayers to improve their spiritual well-being (Simao et al, 2016, p. 1). Similarly, authors argue that because drug users are lacking a spiritual connection with God, this will lead to relapsing (Doerfler et al, 2016, p. 251).

3.3.1.4 Subtheme 1.4: Relatives use drugs due to boredom and unemployed

Boredom and unemployment are factors that are correlate with each other in causing the service users to relapse because, if they are not employed, they become bored and they decide to use drugs again. The service users keep themselves busy with drugs to face the stresses of being unemployed. (Motsoeneng, 2018, p. 1).
. This is explained by the extract below:

> [Being bored, not having something to do.] (P1, F, 26 years)
> [Being bored because he is not employed.] (P16, F, 36 years)
> [Being bored because he is not employed, and he is doing nothing.] (P17, F, 57 years)
> [He told me that, it is because he is not employed] (P14, F,64 years)
> [When he grows up, he was not working but you are buying food, clothes, and toiletries for him and he was not using drugs. When he is saying he is into drugs because he is not working it is a lie.] (P14, F, 64 years)

Similarly, authors concur with the participants that being unemployed is the start of a vicious cycle of relapse and it also encourages drug use (Motsoeneng, 2018, p. 1). The socioeconomic status of the service users when they have no formal means of income encourages them to continue using even if they wish to stop using (Fernandes &

Mokwena, 2016, p. 155). Using drugs increases the chances of the service users losing their job and decreases the chances of them being employed (Motsoeneng, 2018, p. 1).

3.3.1.5 Subtheme 1.5: Users are always in the company of friends who are using drugs

Family is the first social group to which the participants and the service users belong together, and they interact frequently. This makes them develop a powerful connection (Ioan et al., 2015, p. 3), which is affected by the behaviour of the service user when they decide rather to spend time with friends who are using drugs. Lack of interaction between the participants and the service users may lead to recurring of relapse (Matthew, Regmi & Lama, 2018, p. 67).

The service users spend most of the time outside their home but on the streets with their friends who are also using drugs, without regard for the support and the love they are getting from their family members. This means that they have changed their family structure and have come up with a new structure, which is a threat to their families. The participants see the service users as deeply into drugs, which is why they keep on relapsing. They spend most of their time on the streets with friends that are using drugs with regard of the support that the participants are offering to them.

> [How can he stop using drugs because the person who is deep into drugs it is not easy for him to stop? [sounding hopeless]. Most of the time when he goes out, he will be meeting with friends that are using drugs. He can only stop if he can go to rehabilitation centre. When he is still around, he will not stop. To tell the truth I do not know the thing that makes him to go back to drugs]. (P7, F, 54 years)
>
> [The other thing that made him not to stop is that he spent most of his time with his friends who are using drugs]. (P16, F, 36 years)
>
> [I think the problem is that he goes back to his friends that are using drugs. I think that is it.] (P5, F, 60 years)
>
> [I think he is encouraged by peer pressure because most of his friends are using drugs (nyaope). I think that group encourages each other not to stop using] (P9, F, 29 years)
>
> [The environment also affects him because most of his friends are using the drugs.] (P12, F, 46 years)
>
> [He spent most of the time with friends that are using. We are caring and giving him support. Even his brothers are taking care of him, but he does not care. When he wakes

up in the morning, he goes to the street he will come back when he is under the influence of drugs]. (P14, F, 64 years)

[We do not know what encourages him to continue using drugs. Perhaps we are not treating him well in the house, but it is not like that… but for now, I cannot think of anything that makes him to keep on relapsing. Maybe it is the friends he is smoking with.] (P8, F, 62 years)

Some authors agree with the participants that the using of drugs and the behaviour of the service users is because they most of the time outside their home (Motsoeneng, 2018: 41). As such, they are encouraged by their peers not to stop using drugs but to continue (Motsoeneng, 2018, p. 43). The participants see the service users most of the time avoiding or staying apart from them (Ghazalli, Ghani, Abdullah, Chik & Mohd,2015, p. 303). They believe that the service users spend much of the time interacting with their friends who are sharing the same experience of using drugs, which is why they keep on relapsing.

3.3.2 Theme 2: Participants' feelings and reactions after discovering that their relatives continued to use drugs

3.3.2.1 Subtheme 2.1: Participants' feeling of pain and hurt about their relatives' drug use

The participants experienced different emotions after discovering that their relatives have relapsed. Authors explain that relatives of drug users often feel angry, frustrated, anxious, fearful, stressed, depressed, shameful, guilty, or shy (Mancheri, Alavi, Sabzi & Maghsoud, 2019, p. 33). The same feelings were expressed by some of the participants in the following extracts:

[It was painful to me until to date. It is bothering me. He told me that he wants to go back to a rehabilitation centre. I told him that I do not trust him because he went to the rehabilitation centre and when he came back, he uses again] (P5, F,60 years)

[It is very painful to me because at times I ask myself why this is happening to me? It was only him but currently even his younger brother is using drugs.] (P5, F,60 years)

[It was painful, and it affected me to the extent that I ended up taking chronic medication for heart problem.] (P17, F,57 years)

[It is heart-breaking. I remember one day going to his room to reprimand him about his behaviour. I reminded him about the day we went to fetch him at court. It seems as if he was listening to me, but he was pretending.] (P16, F, 36 years)

The findings seem to support the assertion that relatives are experiencing an emotional burden because of taking care of the service users. They are feeling pain and are heart-broken (September & Beytell, 2019, p. 1167). The participants feel continuous pain in their life. They no longer experience peace and happiness since the service users started using drugs (Farzizadeh, 2015, p. 228). It appears that the relationship between them is broken or there is no longer trust between them because they went to the rehabilitation centre, but when they came back home, they used again. The participants believe that the service users are pretenders (Motsoeneng, 2018, p. 29). This has a great psychological impact on the participants as it affects their well-being, especially their health because they are on chronic medication (Sahu & Sahu, 2016, p. 57). Therefore, it means that if the service users are continuing relapsing, the health and the well-being of the participants are at risk of being affected mentally, physically, spiritually, and psychologically (Motsoeneng, 2016, p. 2).

Some participants were sad after realising that the service users had gone back to using drugs again. They felt helpless because they did not know where they can get help since the service users went into rehabilitation, but they soon relapsed. They see the service users as not having good intention about their lives. Their frustrations were captured in the extracts below:

> [… But after realising that he went back to drugs we were so sad again. We love him so much.] (P8, F, 62 years)
>
> [I was sad and feeling helpless.] (P15, F, 67 years)
>
> I was sad because I realised that he has no intentions about his life. There was no one from the family that forced him to go to a rehabilitation centre. He made his own choice and as parents we just gave the support. (P13, F, 48 years)
>
> [I was sad, and it is just that I am stuck. I do not know how and who can assist me. I was very angry towards him to the extent that I shouted at him, and I was also so sad that I even cried because I would not believe that he would relapse.]
>
> [I was seeing that on the street not believing that one day my brother will also get involved into the drugs. You can imagine the feeling of disappointment.] (P7, F, 54 years)

The findings support that it is obvious that the participants can feel constant pain and misery (Farzizadeh, 2018, p. 228). However, the participants still love the service users. This is recognised as a factor in that the participants believe that the service users are still part of the family and that they need to be helped to recover (Ghazalli et al., 2017, p. 309). The participants feel much sorrow and sadness after realising that the service users have relapsed. They even cried because they did not believe that it is happening in their family; they were used to be seeing that on the streets. (Farzizadeh, 2018, p. 229).

Subtheme 2.2: Anger and disappointment

Service users cause their family structure to change by continuing to use drugs again and again and this was a great disappointment to the participants to the extent that they ended up being angry (Motsoeneng, 2018, p. 2). The participants were shocked, disappointed, angry and they even cried after they realised that the service users had gone back to their old behaviour of using drugs. However, when they communicated with them, they were calm because they wanted to show them love and support and they were interested in seeing them going back to school to continue with their own studies or taking care of their responsibilities in the family.

These feelings were expressed in the following extracts:

> [I was so angry towards him, I also wanted to kill him, but it was not possible. I was so angry really]. (P11, M, 37 years)
>
> [I was very angry and disappointed because I was hoping that he will go back to school and finish his matric.] (P12, F, 46 years)
>
> [I even cried when I was communicating with him. I was also disappointed]. (P16, F, 36 years)
>
> [I tried to be calm because if you are harsh towards people like this, they may decide to go and stay on the streets]. (P8, F, 62 years)
>
> [I was very calm after realising that he relapsed but at the same time I was angry. And we forced him to go to a rehabilitation centre to find help. … I communicated with him.] (P9, F, 29 years)

> [We were disappointed. He is our older brother, and we are orphans, we were expecting that he will guide us as we are his younger siblings. We were disappointed by his behaviour of using nyaope.] (P9, F, 29 years)

Similarly, Choate (2016:29) asserts that relatives of service users experience different emotions because they are shocked, angry, and also disappointed after finding out that the service users have relapsed. The participants experience a burden to themselves to face the disruptive behaviour of the service users. They decide to use the following tactics: patient, tolerance, crying, and being calm to deal with the pain they are experiencing by showing them love and support (Farzizadeh, 2015, p. 289).

Other participants believed that the service users will change and stop using the drugs when entering the stage of adulthood. Unfortunately, this does not happen as often as they thought. Currently, they see the situation as a mess and disturbing and they cannot come up with the proper solution. They mention that they advised the service user in terms of dos and don'ts because they wish good things for them. They see the service users as harming themselves and they can also not go far with their lives, especially in education. This tends to disturb them emotionally and they become sad and start blaming themselves. This assertation is expressed below:

> [It was just unbelievable to come to in terms of what is happening and try to convince yourself that he is just an adolescent; he will stop when times goes on. When he enters at an adult stage that is when you become aware that something is wrong, and it is too late because it is just a mess, and you start blaming yourself. What have I done wrong? Because your advice in terms of dos and don'ts nobody in the family is using]. (P2, M, 55 years)

> [It feels like he is harming his own life. Yah! very sad. It appears that he is not from our family because none of us is using drugs or alcohol except him.] (P6, M, 46 years)

> [It was quite disturbing to realise that, ah! the person is using drugs I can say illegal substances, reason being, when you have a family member you just wish them good things. But when you realise this person cannot reach those wishes it becomes a problem especially when you realise that the person is using drugs and cannot go far especially with education or with life only for me but the whole family was disturbed.] (P3, M, 45 years)

According to Choate (2015, p. 468), it is common for the relatives of service users to feel powerless because everything they were trying was not effective. However, even though they were angry they realised that it is not good for them to be aggressive towards the service user but rather to be calm when communicating with them. They also blame themselves because of the situation. They see themselves as failures since they believe that they failed to guide and direct the service user (Yogman et al., 2016, p. 5).

Subtheme 2.3: Painful and stressful

Recurring of relapses leads to conflict in families of the participants and this causes them to be hurt, feel painful and stressful, which is intense and long lasting, and this affects the participants (Mancheri et al., 2019, p. 33)**.** They are always experiencing high levels of stress which affects their health, especially their well-being (Dykes & Casker, 2019, p. 230).

All families have values and morals that they follow and the responsibility of each member in the family is to perform the relevant tasks which they learned from childhood. If any member of the family fails to perform their task, it becomes painful and stressful to the family and parents starts to question themselves about whether they have raised the person well. This is expressed by the extract below:

> [It was so painful to me, and I developed stress. When they say the parents died without any illness, they just fell and die. This is the truth. As a parent I cannot sleep at night you are asking yourself the reasons that pushed him to use drugs because he is getting everything he needs. This causes you the stress because the behaviour of the person changed from good to bad, this makes him the new person in front of my eyes] (P14, F 64 years)

> [Our emotions are not good because he is the breadwinner in the family as he is the first son; he is the one who supposed to assists us in the family]. (P4, F, 63 years).

Some authors concede with the participants. They see the service users as the breadwinner but, because of the drugs, he is failing to perform his duties in the family. The person whom the participants are facing has changed because of his misbehaviour.

This has created the dysfunctional operation in the family (Motsoeneng, 2018, p. 31). The participants see the social structure of the family as non-negotiable, which is why this affects them to the extent that they are not able to sleep at night and they even think that at any time they can fall down and die. They know and believe that all the structures and moral orientation must be learned rather than being created (Cherry, 2015:1). Participants tend to experience considerable stress-related difficulties including insomnia, anxiety and depression. That is why substance abuse is viewed as a family disease which affects all of the family members (Dykes & Casker, 2012, p. 230).

3.3.3 Theme 3: Effects on the users' physical, mental and social well-being

Addiction is a physical, mental and social well-being illness that threatens the health of the service users, the participants, and society owing to all aspects of their progressing life (Mancheri et al, p. 3). The following subthemes will be covered here: effects on the users' physical well-being; effects of the relapse on the users' mental health; effects on the users' interpersonal relationships, and the users' engaging in criminal behaviours to feed their addiction.

3.3.1.1 Subtheme 3.1. Effects on the users' physical well-being

Addiction has devastating effects on the service users (Motsoeneng, 2018, p. 8). The effects of drugs put the health of the service users at high risk to suffer from psychological and social distress, and such conditions would affect their physical and mental health and lead to problems for the service users and other family members. It affects them physically, mentally, and socially. It harms the relationship between them and the people who are close to them (Abdullahi & Sarmast, 2019, p. 1233).

Some of the participants see the drugs affecting the body of the service user physically. They understand that if the service user stops using drugs, they experience certain symptoms that makes them feel pain: they become sick; they have stomach aches. They also believe that service users develop skin problem because of drugs. This assentation is explained in the extracts below:

> [He told me that he is having stomach-ache [withdrawals] and I encouraged him to drink milk so that, the pain can stop. Sometimes I bought him milk. There is nothing that I can do because I am unemployed.] (P7, F, 54 years)

> [Ah! when looking at him I can say, he is deep in this substance. The reason I am saying that is that when looking at his physical appearance it shows that his health is deteriorating. You can see that this person is or may be sick, his face shows loss of weight.] (P3, M, 45 years)

Service users may suffer from severe psychological and physical pain, in that their body becomes very weak, or they may be sick (Singh & Gupta, 2017, p. 187). These are generally regarded as symptoms of withdrawal. Withdrawal is a group of symptoms that occur when the service users stop using drugs abruptly (Singh & Gupta, 2017, p. 187). These symptoms make it difficult for the service users to stop using drugs even if they know that drugs are destroying their lives because they want to avoid unpleasant withdrawal symptoms. The symptoms affect the body of the service user which deteriorates and is unable to function, which is why the participants reported that when the service users are in this situation, it is difficult for them to talk and they can also not walk or be sent to the shops (Sahu & Sahu, 2016, p. 53), as one participant explains:

> [If he is not under the influence of drugs, he is very weak, he becomes ill and he cannot even talk. You cannot even send him to the shop because you can see that he is sick. He is experiencing withdrawals.] (P14, F 64 years)

Other participants observed that addiction destroys the health and well-being of the service users because they develop infections and contagious diseases, such as eczema and they were unable to urinate (Nooripour et al., 2016, p. 9). This was expressed in the following extracts:

> [Drugs affect his mental and health well-being. Sometimes he cannot urinate. I encouraged him to go to the clinic.] (P15, F, 67 years)

> [This drug affected him because he developed skin problem. He has developed eczema. Since he started using nyaope his skin has not been fine. He is always scratching his body. He will not go to the clinic or to the doctor to be treated for his skin problem and it is worse.] (P9, F, 29 years)

The findings seem to suggest the view that the health of the service users is deteriorating. They developed skin diseases, which are caused by low socioeconomic status, malnutrition, overcrowding and uncleanliness (Gupta, Khan & Krishna, 2017, p.

205). Injecting themselves with a needle of drugs causes the skin to develop cracks that cause injury to the body and if the skin is interrupted it can cause a long-term health problem. This is an indication of serious systemic ill health (Coull, Anthern, Taylor & Watterson, 2014, p. 6). Personal cleanliness and healthy living are necessary to decrease the problem of skin disease. Being healthy and having clean skin plays an important role in attracting people and this develop self-esteem (Gupta et al., 2017, p. 203). The participants are also concerned about the service users' hygiene because they have become dirty and smelly. This concern was espoused in the following extracts:

> [Eish! the way it affects him like any drug user he is very dirty, bad smell and even if you buy him some clothes, they don't last a week, or they look like he wore them last month]. (P6, M, 46 years)
>
> [He is not bathing. I wash his clothes and I cannot also wash his shoes and bath him. He must clean himself. I cannot put him in the bathroom so that he can bath… but he does have a bath sometimes.] (P5, F, 60 years)
>
> [Sometimes you feel sorry for him because you can see that he is no longer bathing, and he is also not eating healthy]. (P11, M, 37 years)
>
> [You will realise that his behaviour is changed by not bathing, by stealing from the house and not respecting that is when you can realise that he is into the drugs. You know your child if there is any change you will pick it up. He likes to bath too much but he is no longer bathing, and he is disrespecting adult people when he communicates with them.] (P14, F 64 years)
>
> [Drugs are affecting him negatively. He is no longer bathing, he is no longer eating well, and these drugs affected him mentally because he is just a human being. (Not have plans and does not care about what is going on around him)]. (P8, F, 62 years)

The findings seem to support the assertion that addiction affects the well-being of the service users, who are experiencing trouble as they are hygienically deteriorating because they are not bathing and not eating healthily (Motsoeneng, 2018, p. 8).

3.3.3.2 Subtheme 3.2: Effects of relapse on the users' mental health

Mental health problems such as depression, withdrawal and other dysfunctions are frequently linked to the service users' mental health. They are at higher risk of developing mental illness than non-users (Sahu & Sahu, 2016, p. 56). Mental illness is

caused the by addiction, which is then diagnosed as comorbidity (September & Beytell, 2019:1163). Service users will experience negative consequences that cause memory impairment. Their moods are also unstable, and this causes their strange behaviour (Sewell, 2015, p. 1).

Some participants observed that the service users develop mental illness because they are roaming around the street naked, laughing alone, or marching in the house like soldiers. They were also referred to a psychiatric hospital to be assessed because of the strange things they are doing. These observations are included in the extracts below:

> [There is this drugs that he was using, I forgot its name, it was making him to remove the clothes and running around the streets. You will be called by the community informing you that, the person is in the streets naked. Throwing away his clothes. He was not aware about the strange things he was doing.] (P13, F, 48 years)

> [They took him to Secure Care in Soshanguve and from there, they transferred him to Soweto… and because he was an adult he was taken to prison. At prison they referred him to a psychiatric hospital and the social worker referred him to rehabilitation centre.] *(*P10, F, 64 *years)*

The extracts seem to support the previous findings that the service users have mental illness because they act strangely, they are often involved in behaviours that are terrifying or irritating. Ultimately, some of the service users end up being admitted to a psychiatric hospital to be assessed because of their strange behaviour (September & Beytell, 2019, p. 1168).

Previous studies have also found that service users throw their clothes away and walk naked on the streets, laughing alone and marching like a soldier in the house (Isesebo, Kujula & Majima, 2016, p. 2), as was the case with the story line below:

> [He left school in Grade 8 and sometimes it seems as if he has mental problem. He laughs alone and he can also march in the house like a soldier. If we tell him to sit, he will not listen to us. He will continue.] (P17, F, 57 years)

Similarly, authors contend that service users are experiencing academic problems because they cannot concentrate. Addiction has seemingly affected their brain or their central nervous system, which leads to many complications such as behavioural and health problems (Sahu & Sahu, 2016, p. 56). Moreover, there will be declining grades,

absenteeism from school/college and other activities, and they end up dropping out of school/college (Sahu & Sahu, 2016, p. 55).

3.3.3.3 Subtheme 3.3: Effects on the users' interpersonal relationships

Addiction has caused serious problems in the lives of the service users. It negatively affected how they interact with their family, with colleagues at work and in their community (Volkow, 2020, p. 19). The participants reported that the service users do not have a strong relationship with them or with other family members, their employers as well as with the community. This assertion is explained in the extract below:

> [Most people that he used to spend time with are out of his life, even the closest such as his partner. This shows that he is not moving forward but going backward which becomes a problem and again he now is more like our burden because he does not work anymore. He left his job, and now we must take care of him and his daughter, is a serious burden indeed.] (P3, M, 45 years)

Authors similarly concede that it is common for the partner of the service user to separate from them because they are feeling stressed and burdened, and they are not willing to take care of the service user anymore (September & Beytell, 2016, p. 1164). The repeated threats and the violent acts of the service users made them lose the relationship with their partner (Motsoeneng, 2018, p. 29). Other participants reported that the service users do not have a strong relationship with their employers and as well as the community, as the following two extracts attest:

> [Drugs affected him because no one can offer him a job. His last employer dismissed him for stealing.] (P1, F, 26 years)

> [It was painful to me because some of the community members assaulted him. They assaulted him everywhere. He can be harmed anywhere. It was so painful to me when the community assaulted him... I do not know what to do.] (P10, F, 64 years)

Other participants are not feeling safe because of the threatening behaviour of the service users since their life is always full of conflict and tension (Farzizadeh, 2016, p. 221). This explained in the extracts below:

> [So, the behaviour is also aggressive, easy to start a fight as well. His behaviour changes like weather because sometimes he can be so good like an angel and if you do not know him you will trust him more than the person who is not using drugs]. (P6, M, 46 years)

> [He enters the house through the roof by removing a tile. But I do not know how, he goes out because the doors will be locked.] (P15, F. 67 years)

These extracts suggest that that behaviour of the service users who relapse frequently affected their interaction with the participants and other family members because they behave strangely and aggressively towards them. They do not respect their family members because they shout at them, yell at the children and it is easy for them to start a fight (Sahu & Sahu, 2016, p. 55).

One participant even reported that the user burnt his aunt with hot water and that during the time of the incident she (the aunt) was pregnant.

> [He is not respecting us. He is bothering us in the house. He is shouting at us, yelling at the children. The time he went to prison he had burnt his aunt with hot water, and she was pregnant during that time.] (P17, F, 57 years)

The findings seem to support the view that addiction affects the brain chemistry and the capacity of the service user and this causes them to lose control over their behaviour (Burwell, 2016, p. 1). Their strange behaviour leaves the participants in danger (Farzizadeh, 2016, p. 226).

3.3.3.4 Subtheme 3.4: The users engage in criminal behaviour to feed their addiction

Family members are carrying a burden financially concerning the service users as they are causing a huge financial strain on the participants' family system. This has negative effect on the functioning and well-being of the participants (Dykes & Casker, 2021, p. 226; Sahu & Sahu, 2016, p. 57). On a bigger scale, addiction also costs the economy of the country and there is a great expense to the participants and other family members. It leads to an increase in drug-related crimes such as theft and a loss of resources for the country (Nooripour et al, 2016, p. 9).

The participants' life is changed because of the behaviour of the service user. They believe that they are not safe because the service users are stealing their belongings. For instance, if the house is locked, they break the window, and this also needs money

to be fixed. They also steal from the community and from their neighbours. The participants reported that the service users steal from the community. The worst part is that they also sell their clothes so that, they can get money to feed their addiction. This explained by the extract below:

> *[He steals my baby's belongings, for example: Pampers, baby food, clothes and toys and I am a single parent not working if he steals those things how am I going to replace them? If he steals from the house, he spends some days with friends not coming home. Currently, he has not been coming to the house because my mother gave him transport money to attend a ceremony at his aunt's place. Instead, he used it to buy nyaope*.] (P1, F, 26 years)
>
> *[He broke the window and entered through it in the house so that he can steal. The window was fixed but when we are going somewhere we tell him to go out of the house so that we can lock the door because no longer have trust in him.]* we are (P13, F, 48 years)
>
> *[He is stealing everything from the house. He is stealing the money. Currently I bought face lotions and when I came back from Nelspruit [town in Mpumalanga Province, South Africa], I found them being stolen. I do not know between him and his brother who stole those things. There is my grandson who is at Grade R. He told me that, the person who opened my bedroom door with the spade so that he can steal is the younger drug addict. He ran to call his mother when she arrived, the door was already broken.]* (P14, F 64 years)
>
> [*It was sad when he relapsed because when I found out that he had stopped drugs I was happy. But, when he went back to drugs, we are not comfortable because most of the time he is stealing from the house*.] (P1, F, 26 years)
>
> *[It is a lot of risk having him around. Sometimes when I am visiting my parents' home I leave my valuables like money, and my bag in the car. Imagine I am home in my bedroom, but my things are in the boot of a car. This is the life that we are living when we have people who are using drugs*.] (P6, M, 46 years)
>
> *[He is stealing from the house. There are also complaints from other community members. The complaint is about him stealing from them. Or taking belongings of other people. We are not feeling safe because he steals from us if you put something, we know that there is possibility of not finding it. He will never agree that he took it*.] (P16, F, 36 years)
>
> *[Every time when he goes out to smoke drugs, the first thing he do is to steal from the house. He will always lie to us that he wants money to register so that he can go back to school.]* (P11, M, 37 years)

Service users are very often unemployed, and this makes them get involved in criminal activities such as stealing money, the belongings of family members and household

items, and selling them to purchase drugs. They also commit house breaking and theft, breaking the windows and doors (Dykes & Casker, 2021, p. 233). Participants and other family members are financially strained because of this theft and housebreaking (Sahu & Sahu, 2016, p. 57).

3.3.4 Theme 4: Effects of relative's use of drug on the family's well-being

The behaviour of the service users affects the well-being of the participants and some of the family members. This makes it difficult for them to focus on their own interests (Dykes & Casker, 2019:29).

The following subthemes will be covered under this theme, namely the effects on family's well-being, and strained family relationships.

3.4.4.1 Subtheme 4:1: Effects on family's well-being

The function of the family is offers environment that provides safety and security for successful development and must be emotionally involved with each other's and be able to influence each other's family roles especially where strange behavior challenges the emotional bond (Radebe, 2015, p. 81). Social support and strain have long-term consequences for health and development (Kutschke, Bengston, Seeman & Harris, 2017, p. 174).

One participant is frustrated and hopeless about the ongoing relapse of the service user. The participant tried many options to assists the service user, but all the options failed. The participant, as a father, ended up thinking that the service user is not yet ready to change, and decided to chase the service user from the house. As a father he came to the sense that the service user need help. This situation not only affects him as a father but also his children and the marriage. The participant feels helpless; he does not know what to do. The participant's experiences are captured in the following extract:

> [There is a lot of anger and frustration. You know, sometimes you develop hopelessness. I must just surrender because this person is not ready, I must kick him out of the house and at the same time you realised that you are taking the decisions that are wrong, have a sense of giving support. When you think of chasing him from the

> house, there is something that tells you that as a parent what you are doing is wrong. Then it is a very stressful situation, and you ask yourself what direction to take with the issue. These are the dilemmas you are facing. Can I do this? Can I do that? You ended up losing direction like him, you don't know what the right thing is to do then there is a lot of frustration. It is also affecting other sibling and your marriage.] (P2, F, 55 years)

Authors similarly agree that it is a challenge to accept or to deal with the addiction of the service user in the family and this touches every member of the immediate family (Dykes & Casker, 2021:226). This causes the family to experience emotional and psychological stresses and distress, which partly emerges from the increased responsibilities that the family is subjected to and their limited ability to cope with the caring responsibility (Madiga & Mokwena, 2022, p. 2).

Families experience a lot of hurt and frustration as the service user acts violently and aggressively towards them, which makes the family live in fear and anxiety (Radebe, 2015, p. 71). Similarly, the participants are affected by the service users' addiction as they cannot control them.

The participants do not feel safe, and this affects them to the extent that they are unable to sleep at night because they think the service user will harm them, especially because they are behind closed doors and their neighbours will not be able to help. This affects them emotionally and that also makes them unable to sleep, as one participant explains in the extract below:

> [When I am asleep and immediately when I hear uncomfortable sound, I wake up look around because I am thinking that he wants to steal a car. I do not feel safe. During the day I do not mind but during the night because doors are closed and neighbours are asleep, I am afraid that he can harm me because most of the time he is forcing me to give him the money.] (P15, F. 67 years)

Families and relatives are financially crippled (Arlappa, Jha & Jayaseeli, 2019, p. 66), because of the theft, breaking of the property and other general living costs (Groenewald & Bhana, 2016, p. 2) that are incurred by the service users. The worst part is that the other family members must replace those valuables that have been stolen

from the neighbours and this leads them to face more financial challenges (Nkosi, 2017, p. 43). These financial losses are captured in the following vignettes:

> [He is using nyaope. This affects me because when he started it, was so painful to me. I was unable to sleep even currently I am unable to sleep. Sometimes I buy him some clothes and he sell them like now it is winter I bought him sneakers and he sold them; he is feeling cold. It breaks my heart because we want to see him eating well and wearing warm clothes. He is not staying in the house most of the time he spends it with friends on the street.] (P8, F, 62 years)

> [We are facing financial challenges because we can buy grocery for example, today and the following day you find out that he stole some of it. It affects us financially]. (P9, F, 29 years)

Service users' addiction affects family members emotionally (Dykes & Casker, 2021, p. 226) and psychologically like experiencing difficulties in sleeping, headaches, fear, low self- esteem, guilt, and anger, (Johannessen, Tevik, Engedal, Tjelta & Helvik, 2022, p. 2; Madiga & Mokwena, 2019, p. 2). depression, suicide, insomnia, emotional distress including feelings of shame, blame and humiliation (Groenewald & Bhana, 2016, p. 2). These assertions were also explained by one of the participants:

> [It affected my mother a lot. We can manage to cope with this situation, but my mother cannot cope. This situation affected her health, she is always in and out of the hospital. She was hoping that my brother will have a brighter future. Her diabetes and her high blood are uncontrollable. She wants to see my brother being a changed person]. (P11, M, 37 years)

Similarly, authors explain that having the service users in the family is said to have negative emotional impacts that leads to physical consequences. In addition, the emotional impact of the addiction on the family members may cause problems that are medically related, such as diabetes and high blood pressure (Nkosi, 2017, p. 39). According to Olafsdottir (2020, p. 87), other family members are experiencing high levels of stress which significantly compromises their health and subjective well-being.

3.4.4.2 Subtheme 4.2: Strained family relations

For better for worse family relationship play an important part in an individual's well-being across the whole life (Thomas, Liu & Umberson, 2017, p. 1). Addiction causes a high risk of compromising and shattering the relationships in the family setting which

lead to the family system being strained (Hlungwani, Ntshingila, Poggenpoel & Myburgh, 2020, p. a2137; Shamsaei et al., 2019, p. 6) This causes psychological strain on the connection of the relationship, especially for their mental well-being, which results in emotional stress (Radebe, 2015, p. 82). Similarly, authors acknowledge that addiction often leads to break down the family relationships since family members both nuclear and extended, may experience feeling of abandonment, anxiety, fear, anger, embarrassment, or guilt and this motivates the service user increasingly to separate from their families (Shamsaei, Baanavi, Hassanian & Cheragi, 2019, p. 6).

The relationship between the participants, other family members, service users, and extended to the neighbours and the community is broken. The service user steals from them, and they are also acting violently and aggressively towards the participants and the people around them. This is overwhelming to the participants and the people around the service user. This strained relationship is explained in the following extracts:

> [The relationship changed because there is no longer trust between us]. (P1, F, 26 years)
>
> [Very disappointed because during the process we have lost appliances, tools, the grinders, and we also lost other things that we have plans about them. We are no longer buying those things. Imagine buying something for five thousand rand and the next thing you are going to lose it. We ended up hiring someone to fix things that we can do for ourselves and pay them because we are no longer have the equipment. We are losing a lot of money and a lot of things in the house. And it is not only us even the people in the community end up being his enemies because he steals from them too.] (P6, M, 46 years)
>
> [The person you are trying to help does not see it that way. His siblings and the wife are complaining these put pressure on you at the end of the day. Sometimes you feel like this person you are trying to help and others who are using drugs must be locked in prison. One loses a lot of things like money. Taking leave from work is stressful and end up lying to the employer it is a very serious problem].
>
> [The other kids feel neglected because their father is always focusing on this one. It is always a confusion, always a fight is either I fight with kids or my wife. You do not see the neighbour the way you were seeing him before his /her attitude towards you changes because this person steals from them.] (P2, F, 55 years)
>
> [Our relationship is broken, and we will never be able to build that bond again]. (P14, F 64 years)

> [He is disrespectful towards us. Most of the time we avoid communicating with him because when you communicate with him, he will be aggressive towards us. Even if you can see that he is doing wrong things, you just observe him. We are only females in this house, except him because of that, he is disrespecting us.] (P17, F, 57 years)
>
> [His behaviour has changed. He started to be violent towards us and his eyes are always red, and he comes home late at night.] (P12, F, 46 years)

The behaviour of the service users strained the social life of the participants and other people around them (Hlungwani et al., 2020, p. 7). The service users do not change their way of living, and this causes conflict and trauma in their personal relationships that they may not be able to rebuild again. It not only destroys their relationship with the participants and other people within the families but external relationships beyond the family, like those with neighbours and the communities (Nkosi, 2017, p. 36).

3.3.5 Theme 5: Efforts by participants and the family to assist relatives who are relapsing

Strong family relationships and love are identified as factors that lead families to assume the addicts are still part of the family system and that they need to be helped to recover (Ghazalli et al, 2017, p. 310). Families that are taking good care of each other could assist addicts effectively to overcome negative aspects of their emotions (Choate, 2015, p. 470). These efforts by participants and assistance by family members will be discussed in the following subthemes: participants' efforts to assist their relative who is relapsing; family involvement to assist relatives who are relapsing and service users' motivation to deal with their addiction.

3.3.5.1 Subtheme 5.1: Participants' efforts to assist their relative who is relapsing

Parenting is a process in which children recognise appropriate or inappropriate behaviour by learning what is right and what is wrong. Through parenting, parents also understand the roles and the norms of their family (Casker, 2019, p. 26). In an addiction environment parents or caregivers are always conflicted as to whether they should offer support to the service users and try to offer a stable environment to their siblings (Casker, 2019, p. 27). Providing support to service users cannot be easy without having

knowledge or information about the mind-set and the patterns of their addictive behaviour (Sari, Fatah & Nurmala, 2021, p. 61).

The participants still have hope after several relapses of the service users, which is why they encourage them to go to the rehabilitation centre. Furthermore, they keep on advising them about the dangers of using the drugs and try to find out from the service user the pressing issue that causes them to keep relapsing (Choate, 2015, p. 466). They still see a brighter future in the service users' life, as was the case with some of the participants in the storylines below:

> [I sat down with him to find out what is bothering him because he keeps on relapsing. He lost his first job and I decided to talk to my friend so that he can offer him a job and my friends understand the situation that we are in as a family, and he offered him a job at the tavern]. (P1, F, 26 years)

> [I sat down with him to make him aware of the danger of drugs and encouraged him to stop using them… He has the skills of communicating with people. That is why I wanted him to become a social worker. And if he succeeds in life, he will tell his children about his past. Eish! I do not know what to do, sometimes I asked myself why God is doing this to me?] (P10, F, 64 years)

> [I am the one who keeps on communicating with him because he is currently from prison. He went there for years.] (P4, F, 63 years)

> [I did try to sponsor his work as I already said he is more skilled. However, I also ended up losing the equipment and he did not pitch to do the work as promised. So, I ended up taking part lying to the customers to cover him up. So, I keep thinking on how I can help him, but he needs close supervision and close monitoring, but many attempts failed.] (P6, M, 46 years)

> [I was accompanying him to SANCA [South African National Council on Alcoholism and Drug Dependence] to make sure that he reached the place. He was doing after care, and it was assisting him to forget about the drugs. There is another drug that, they named it blue tooth [the participant named it blue tooth, but this is not the name but the process in which the service users used to inject themselves] I told him that he must not use it. Blue tooth is dangerous it can kill you because you are injecting yourself with the other person's blood. If you are not sharing the injection is better. Sharing the injection is bad because we are having different diseases in our body, and we can infect each other if we are using the same injection. All our blood is red in colour, but it is not the same type and to take other people's blood is not safe; you can be crazy for the rest of your life. Do not use blue tooth]. (P10, F, 64 years)

> [I went to the social work to assists me so that he can go to a rehabilitation centre. His maternal family does not care about him. Currently I am planning to go to the social

> worker to assists him to refer him to a rehabilitation centre. because if I die, he is going to suffer] (P15, F. 67 years)

The findings seem to support the view that family members of the service users are feeling powerless and that nothing they were trying seemed effective. Nothing seems to keep the users away from the temptation of drugs (Mathew et al., 2018, p. 71). Masombuka (2013, p. 115) claims that some of the family members lack the skills to manage the misbehaviour of the service users; hence, some of them decide to seek professional help at treatment centres. Moreover, the participants experience feelings of hurt, frustration and much psychological pain and hopelessness since the service users are not taking responsibility of having a better future (Radebe, 2015, p. 72).

3.3.5.2 Subtheme 5.2: Family involvement to assist relatives who are relapsing

The family environment is a place that family members perceive as a collection of expectations, a place to tell stories, a place to ask questions, a place to issue complaints as well as a platform where service users can express their feelings, which can be helpful to their recovery should there be a need (Sari et al., 2021, p. 61). Family involvement can encourage the service users to enter treatment and enable them to pick up signs of relapsing before the actual episode (Daley, 2013, p. S75). Family members of service users articulate their needs, feelings and wishes even though their families face the challenges of a dysfunctional family in terms of cohesion, communication support and organisation (Casker, 2019, p. 26).

The participants tried several decisions which they thought would help but have failed. The family members gave the service users advice about the dangers of using drugs. They encouraged them to go back to rehabilitation centres so that they can have better futures. These efforts are encapsulated in the extracts below:

> [We [participant and other family members] tried to show him that dagga is a problem and the disadvantages of using it. We took him to rehabilitation centre. He always comes with the resolution of changing friends. You cannot even be able to find out if he is changed because when he came back, he goes straight to his old friends that are using drugs. He is always disappointing us because he will say he is changed and he want to continue with his studies, we will register him as his wish, but he will have ended up dropping his studies because of drugs]. (P2, F, 55 years)

> [Mhh... we [participant and other family members] first actually sat down with him to try to highlight what is going on with his life. Secondly, we ran around for some help to a point that he ended up in a rehabilitation centre. We were assisting with whatever support that we might think of, financially and then ah! socially and even psychologically in terms of encouraging him. We will advise him to take opportunity of going to rehabilitation centre.] (P3, M, 45 years)
>
> We [participant and other family members] have relative in Limpopo [Province] and he was taken there because drugs are not popular there. We also bought him a medication known as methadone to assist him with withdrawals so that he cannot think of using.
>
> Another friend of mine told me that, there is the doctor in who can assist him. I went there but he never got assistance. However, the doctor told us that, if the family member is prepared to stop using drugs, he will but if he is not yet ready, he cannot stop. The doctor explained that he is only going to give us the medication that will stop him feeling pains. (P8, F, 62 years)
>
> [We [participant and other family members] are trying to find a casual job for him so that he can be able to feed his habit. so that he cannot steal in the house and from the neighbours. We are also planning to take him to a rehabilitation centre. He will go back to rehabilitation centre again.] (P9, F, 29 years)
>
> [We [participant and other family members] are trying by giving him support and we also took him to a different rehabilitation centre because we thought the first one was not good, let's try the second one. But there is no change in his behaviour at all. We keep failing]. (P11, M, 37 years)

The findings seem to support that families provide more information about the dangers of drugs and how it will destroy the life of the service users, hoping that the service users will stop using drugs, but they failed (Sari et al., 2021, p. 61). They took a major step crying out for help; however, it was often described as disappointing and failed to make a difference as the service users relapsed (Choate, 2015, p. 469). Furthermore, families know that if the service user continues being into drugs for a long time it will destroy their future (Sari et al., 2021, p. 61).

When the service users were reprimanded to stop using drugs by participants, service users promised to stop but they never did. Family members tried to involve them in the household chores to show them that they are part of the family and that they still value them. This also failed since the service users did not stop using drugs; instead, they relapsed. This assertion is explained below:

> [We [participant and other family members] sat down with him and reprimanded him. His father already tried, and his uncles reprimanded him, and he keeps on saying I will quit the drugs, I will quit the drugs, but he did not fulfil his promise. He is still using drugs**.]** (P13, F, 48 years)
>
> [We [participant and other family members] tried to reprimand him and advises but when you speak to him, he will shout at us.] P17, F, 57 (years)
>
> [We [participant and other family] always reprimand him, but he continues using … However, he is not bothering us in the house because he is employed.] (P4, F, 63 years)

Participants and other family members focused more on the service users' behaviour and made hardened decisions towards them which impacted their relationships negatively without their understanding that service users have inconsistent symptoms (September & Beytell, 2019, p. 1171). The service users were never harshly spoken to when being reprimanded (Ghazalli, 2017, p. 308).

The participants and other family members realised that the well-being and the functioning of the family was disrupted by the service users, and they decided to put measures in the place to ensure that little impact is required from them (Motsoeneng, 2018, p. 30). This assertion is explained below:

> [We [participant and other family members] encouraged him to stop drugs and observe the life of his friends that he passed matric with. They have achieved a lot. He will lie to us and mentioned that he has quit drugs. But we can see that he is still using them.] (P13, F, 48 years)
>
> [We [participant and other family members] started talking to him trying to show him that the results of what he is doing is bad. We realised that the more we talk to him, the more he became worse.] (P16, F, 36 years)
>
> *[*We [participant and other family members] encouraged him to go and see a counsellor and the social worker to get counselling and we also encouraged him to go back to school, you know. And forced him to do the chores in the house so that he can be focused. He must first be clean and go back to school afterwards because he cannot concentrate at school while he is busy with drugs. He would not focus.] (P12, F, 46 years)

> [I sat down with him and tried to find out why he has changed. And he refused to tell the truth. I decided to involve his brothers in this matter, and we had a family meeting with him. His brothers also tried to find out the truth from him, but he denied that he is using drugs. But we could see that he is using them.] (P8, F, 62 years)

Interactions from family members are imperative as they channel emotional, instrumental, and informational support to service users (Ghazali, 2017, p. 303). They keep on supporting the service users and yearn to keep them within the family by instilling positive ideas and information in their lives (Masombuka, 2013, p. 120). Moreover, participants and family members were listening to and giving advice to the service users (Ghazali, 2017, p. 303). The participants want service users to have a better future (Ferrey, Hughes, Simkin, Lockkock, Kapur, Gunnell & Howton, 2016, p. 1).

3.3.5.3 Subtheme 5.3: Service users' motivation to deal with their addiction

In most instances, the service users have been to a rehabilitation centre several times and none of them have been able to remain sober after that. Despite factors that pushed service users to relapse, they still wished to go back to the rehabilitation centre in the hope that they will stop using drugs and achieve their goal of being sober (Motsoeneng, 2018, p. 34)**.**

Participants and family members mentioned that service users want to change their misbehaviour and are prepared to go to the rehabilitation centre. This assertion is expressed in the extract below:

> [I did not try anything; he is the one who is volunteering to go to rehabilitation centre in future. We believe that maybe this time he will stop.] (P1, F, 26 years

> [People from SANCA [South African National Council on Alcoholism] arrived and gave him forms in my presence to complete. He told me that he went to their offices. I do not know the services they are rendering. I just heard from him that he went to SANCA to fill in forms and it ended up there. Until today, we are still waiting]. (P5, F, 60 years)

Service users are motivated to quit drugs because they are worried about their future, health, income and their legal issues (Choate, 2015, p. 466). The service users often request support from their family members to accompany them to the rehabilitation centre (Motsoeneng, 2018, p. 40). However, some service users are not prepared to change their behaviour because they refuse to go to rehabilitation centre. This is explained in the extract below:

> [My mother completed the form so that he can attend after care. However, when the date arrived to go to SANCA, he just disappeared. Even the correctional service official tried to take him to a rehabilitation centre but when the day arrived, they find him disappeared.] (P16, F, 36 years)
>
> [He does not want any assistance. The social worker that is employed at SANCA wanted him to attend after care programme before going to a rehabilitation centre. He told me that he cannot go there.] (P17, F, 57 years)
>
> [I have communicated with him, but he said he cannot stop.] (P4, F, 63 years)
>
> [I communicated with him about the whole situation, but he was not prepared to stop.] (P13, F, 48 years)

The findings seem to suggest that participants also realised that trying to connect the service users with professional services was not easy as the service user often refused (Choate, 2015, p. 469). It is not easy for the participants to convince the service users to go to a rehabilitation centre (Motsoeneng, 2018, p. 36).

Participants and family members experienced several emotions such as helplessness, fear and worry because they were not happy with the service users' decision not to go back to the rehabilitation centre since not going back could result in destroying the service users' future. This threatens their own safety, as well as that of others (September & Beytell, 2019, p. 1172).

The service users are not motivated to stop using the drugs. (Motivation is an extending to which service users are willing to change their problematic substance use behaviour or to opt for positive behaviour change. Service users rely on drug addiction to help them face their daily lives and to help them to deal or cope with feelings, thoughts, and situations; hence, they are not motivated to change (Swanepoel, 2014, p.84).

3.3.6 Theme 6: Participants' coping mechanisms.

Coping is a dynamic process defined as the established of resources which an individual usually uses to solve or improve a difficult situation and to reduce the tensions that this situation might generate (Martinez-Montilla, Amador-Marin & Guerra-Martin, 2017, p. 593). Coping also refers to the cognitive and behavioural efforts to manage, decrease, or accept the demands of the situation (Baqutayan, 2015, p. 481). The whole family system is impacted by the behaviour of the service users, and it puts them at

higher risk of not being able to cope. It destroys the interaction of the family, which steadily grows weaker and, as these changes occur, it influences participants to lose their control (Choate, 2015, p. 468). However, the participants and other family members are handling this situation in different ways. Some can cope with this situation even though it is not easy, but some are unable to cope.

Some participants are overwhelmed by the burden of the service user's behaviour as they explain in the extracts below:

> [It is not easy for me, but there is nothing I can do, it is not easy for me. Since their father passed on these children [ten]… I am the one who is giving direction and guidance when they are lost. He [service user] got arrested and I am left with his younger siblings [girls]. I am the one who is taking responsibility for the family. I make sure that they go to school, and you are always thinking about a lot of things sometimes I reprimand myself about thinking lot.] (P4, F, 63 years)

> [It is not easy to live in this because it is overwhelming. When you have a trip, you must find someone to remain in the home. That person must guard everything in the house. This is not life.] (P14, F 64 years)

Similarly, literature concedes that participants and other family members find some way of coping with the situation by being more effective in protecting them from the stress affecting them negatively, while they are also preventing or reducing the strain, they and other family members are experiencing (Masombuka, 2013, p. 102).

Some family members managed the situation by controlling and monitoring every step that the service users are taking in the hope of saving them (Baqutayan, 2015, p. 468).

Counselling allows individuals to express their feelings about the challenges they are experiencing, so that they can get guidance and advice about the situation (Choate, 2015, p. 469). During counselling, individuals are empowered with more information on how to deal with the addiction behaviour of the service users, so that they can acquire more skills to use and to handle the situation they are in, to restore peace and harmony (Olafsdottir, 2020, p. 87). One participant is not coping and seeks counselling. This plea is made in the extract below:

> [It is very stressing having the person who is using drugs in the house. I am not coping personally. I need counselling. I need counselling. I am not coping at all because I have

> lost lot of things in my house because he is taking everything so I cannot buy anything. I am scared.] (P12, F, 46 years)

Families play an important role in the life of the service users. They are giving them support so that they can stand up for themselves to protect and manage their behaviour effectively and to increase their help-seeking behaviour from specialised services and support groups (McCann et al., 2017, p. 1).

> [It is not easy to say I am coping because the person who is using drugs it means a lifetime threat especially if they are not having anything to do for themselves on their own. One of the things that we are trying to do is to give him support as I said he is so skilled in many kinds of jobs.] (P6, M, 46 years)

Drug addiction is one of the most stigmatised conditions in comparison with other mental illnesses. Stigmatisation is an overall stereotypical and prejudicial process that includes reductive labelling, status loss and discrimination regarding the individual (Sattler, Escande & Racine,2014, p. 423). One participant is not coping, because the community members are stigmatising him and this situation pulls her down. The participant explains the situation in the excerpt below:

> [Honestly, I am not coping, I am trying to be strong, but people are labelling me. When I am down the street, they will say ah! that lady is the sister of that nyaope boy. They are labelling him, and I also feel like I am a nyaope person. People are laughing behind our backs.] (P11, M, 37 years)

The extract highlights that stigmatisation impacts the participants to develop stress and violence and it forces the families not to go out to ask for help but rather to engage the problem directly, tolerating the problem or withdrawing from the service users (Casker, 2019, p. 24). This stigma is likely to frustrate the relatives of service users since they feel that the community members isolate them and they accuse them of encouraging the behaviour of the service users instead of realising that they are also bothered by their behaviour (Mathibela & Skhosana, 2019, p. 97). Furthermore, community members made the participants and other family members feel isolated, rejected, and that they are outsiders in their own community as they are being judged because of the behaviour of the service users. They must face the challenges of being called names by the community members (Mathibela & Skhosana, 2019, p. 97).

Some family members are constantly worried about the safety and health of the service user. Their concerns and worries are captured in the extracts below:

> [We [participant and other family members] are not coping because we cannot sleep at night. If you hear someone screaming at night, you think it is him. Even when you eat you think about him. His dirtiness also affects us because you find that we are clean going to church, but the person is dirty]. (P8, F, 62 years)

> [We [participant and other family members] are trying to cope but situation sometimes we are afraid that, when he is out of the house what is he doing out there, maybe he is going to steal from the community because in the house he is no longer able to steal anything.
>
> You are always anxious you no longer feel free especially when it starts to be dark you start to be scared. Asking yourself where he is.] (P13, F, 48 years)

Family members are worried about the unpredictable behaviour of the service user, especially if he is not at home. They ask themselves what kind of crime the service user is committing out there, because they are not trustworthy (Casker, 2019, p. 4). Moreover, the participants and other family members become emotionally exhausted because they are always worried about the health and the well-being of the service user (Casker, 2019, p. 4).

One participant is not coping with the situation because the service user did not take long before going back to drugs again. The family thought that he was not prepared to change, and they stopped giving him support in everything. However, they realised that it is not helpful to stop supporting him. Then they decided to continue to assist him. This frustration is explained in the extract below:

> *[Ah! I cannot say we are coping because we know that the same person is still using drugs. The experiences are not the same the first time we hoped that it will work because he was from rehabilitation centre, and it means he learned a lot, then he is going to stay sober for long but that did not happen as we thought. He relapses immediately, this make us think that he is not serious. On the third time, we decided not to assist him anymore; we cut everything that will help him, which was a form of punishment as well, but at the same time we feel that we did not do enough. We keep on saying let's try again, so it is like we are running in circles but coping, we are not coping.]* (P3, M, 45 *years)*

Some families have done all that they could think of to address the problem but every option they used has failed (Choate, 2015, p. 471). They lost hope because they believe

that the service users will never change their addiction behaviour; instead, they were getting worse (Choate, 2015, p. 470). This forced some families to stop offering the service users any kind of help they need. However, they realised that still this is not benefitting them; then they continue giving support. Families are confused because they do not know what to do.

3.3.7 Theme 7: Participants' suggestions on the improvement of inpatient treatment programme

Better services are recognised as improving the inpatient treatment programme, which can satisfy the participants, the community, the service users, and other family members (Ramya, Kowsalya & Dharanipriya, 2019, p. 38). The participants suggested the following improvements of the inpatient treatment programme, namely: extension of the service users' period of stay in the rehabilitation centre to develop skills; inpatient treatment centres should eradicate the self-discharge policy; inpatient treatment centres should improve security and services; and inpatient centres should offer better services.

3.3.7.1 Subtheme 7.1: Extension of service users' period of stay in the rehabilitation centre to develop skills.

The rehabilitation centre is used as an option to rehabilitate the service users in terms of their addiction. It has social workers playing an important part in the life of the service users in rendering educational and motivational programmes (Mathibela & Skhosana, 2019, p. 113).

Some of the participants expressed dissatisfaction about the duration for which the service users stay in the rehabilitation centre. They want the duration to be extended. They want the treatment to be extended to six months, one year or two years and they are also wanting the rehabilitation centre to have developmental skills so that they can help the service users to be employed when going back into the community. This assertation is explained in the extract below:

> [I think they must change the duration of their stay in the rehabilitation centre because they are staying only six weeks. They must keep them for a longer period maybe for six months. When they are discharged after six weeks, I think they are still craving for whatever they were using. If they can keep them for six months, I think things will be better.] (P9, F, 29 years)

> [The way they are rendering the programme is not working because they start offering the programme in the second week the person is admitted. They are still very weak and sick they cannot be able to concentrate on what they have been offering. They mixed the new admissions and the relapse people in the same group. How do they rehabilitate people who are addicted to drugs within six weeks? They are discharged to the same environment that where the problem lies. It is a short period of time and things were not fixed in the community and at home.] (P2, F, 55 years)
>
> [They treat them and release them when they are still fragile. Six weeks is a short period. They must stay there and enrol there; the treatment must be long]. (P2, F, 55 years)
>
> [I wish they could extend the time of stay in a rehabilitation centre. Six weeks is not enough. I think they came back home while they are still craving drugs. That is why they are not staying long before they go back to drugs.] (P11, M, 37 years)
>
> [I would like them to change the period of six weeks' programme to prolong it to six months or a year.] (P13, F, 48 years)
>
> [The time he went to the rehabilitation centre; he did not finish the programme. They brought him back because there was no water. They said they will contact him but later I heard that, all the people went back to rehab. I tried to find out from his social worker, but she mentioned that they give him a letter the day he was discharged to give her as a contact person to indicate the date he must return to the rehabilitation centre. The date was on the third August 2021. Maybe if he can be admitted again, he will be a different person, but I am not sure. I am not in his heart.] (P14, F, 64 years)

Similarly, Volkow (2018, p. 4) argues that the service users also need at least three months in treatment to be able to reduce or stop their drug use, this will bring the best results. However, the author cautions that the participants and other family members must be aware that service users are unable to be clean from drugs for a longer period because they were addicted for a long time. The prolonged addiction affects the functioning of the brain severely, which caused many behavioural consequences and an inability to resist the craving to use drugs despite adverse consequences (Volkow, 2018, p. 4).

Some participants suggested that the inpatient treatment centre should be extended from two months to at least two years. They want the treatment centre to teach the service users skills that can help them to find a job when they go back into the

community. Some of the suggestions to extend the duration were expressed in the following extracts:

> *[Maybe the treatment needs to be prolonged to somehow until such a time they can see that the person has changed or until they install a sense of humour in him. Maybe there must be treatment and the other part be skills development centre. Most of the time this thing of quitting the drugs and going back to school is not working. It will be good if this happens in the treatment centre. For example, if it is N1, after the person completed training, he must be acquired a N1 certificate. They must be equipped with the resources to become independent. Maybe after that he will be motivated to say no to drugs. The person may be proud of themselves saying that they have graduated and ready to start their own business.] (P2, F, 55 years)*
>
> *[I think they should stay for six months. However, I also wish they can stay for a year before they are discharged. I wish there will be a school so that they can be able to build their future.] (*P17, F, 57 *years)*
>
> *[There should be skills development programme certificate. When he comes back with a qualification it will be best. For example, if someone is an electrician, he will contribute to the community. Unlike this short-term treatment, rather than talking about drugs].* (P2, F, 55 *years)*
>
> *[I think that they should be accommodated for two years so that they can change and have direction in life. I think maybe he [service user] can come back having different certificates. For example, the person can stay long in prison but when he comes back, he will be having different certificates. He can be a mechanic; he can bake, and he can do a lot of things. Even in rehabilitation centre they must adopt that so that when the service user comes back home, he must be knowing something. It will assist them if they can extend the time to two years.] (*P11, M, 37 *years)*
>
> *[I want them to change the time that they are staying at rehabilitation centre. I wish they can stay for a year because six weeks seem as if the child never went to a rehabilitation centre. If they can teach them hand skills. Like teaching them bricklaying they become well skilled.] (*P15, F. 67 *years)*
>
> *[I wish they can teach them hand skills during their stay (of six months or a year) in the programme so that they can acquire certificates which will assists them when they are discharged.]* (P13, F, 48 *years).*
>
> *[I think they must also make sure that, the skills that are rendering to them are more convenient so that they will be able to implement them outside the rehabilitation centre.] (*P12, F, 46 *years)*

The participants' suggestions seem to resonate with the assertion that rehabilitation centres should take steps to empower spiritual growth and to improve functioning in

service users and their families, by planning and implementing proper educational interventions (Izadabadi, Tirgari & Pouraboli, 2019, p. 120). Moreover, they must implement developmental skills so that they will train the service users as artisans in the field of electrical work, painting, welding, tilling, and plumbing as part of narrowing the gap of critical technical skills according to the Skills Development Act 97 of 1998, as amended (Kheswa & Lobi, 2014, p. 617).

Authors encourage families to support the service users and to accept them unconditionally, so that they are able to manage stress and tension on the road to recovery to ensure a successful rehabilitation process (Ghazalli et al, 2018, p. 59). Similarly, Manelli (2013, p. 636) argues that family members play a crucial role in the life of the service users. They are giving them support regarding their health and well-being, such as direct care, financial assistance, and management of the symptoms of illness as well as encouraging them to participate or cooperate in treatment centres (Manelli, 2013, p. 636).

One participant realised that it is important for family members to visits the service users while they are in rehabilitation centres because it is a part of giving them support, encouraging them to complete the programme.

> [*Through the experiences that I have learned from my brother, people who are challenged with drugs need more time and attention. So, the time they spent in a rehabilitation centre I think is not enough. I think they need to spend more time there. And then the other thing that I have noticed, especially late during COVID19, we were not allowed to visit them which was a challenge because I think the rehabilitation centre needs to come up with ways of allowing us to provide social support like visiting them, encouraging them to stay long or move on with whatever that they are doing but due to the pandemic the visit was cut. The rehabilitation was not doing enough in terms of coming up with ways of allowing us to see them.] (*P3, M, 45 *years)*

This extract highlights the important role that family members can play in motivating service users to enter and stay in treatment (Volkow, 2018, p. 14). Moreover, family support is recognised as one of the most important supports that need to be present not only during the rehabilitation process but also during post-rehabilitation, to ensure a successful recovery for the service users and to help them in preparing for the new

phase of their life (Ghazalli et al, 2018, p. 62). Therefore, the participants and family members are encouraged to visits service users while they are in an inpatient treatment centre because that forms part of family therapy. This motivates the service users to feel the sense of belonging which will assist them in recovering faster (Adzrago, Doku & Gyamfit, 2018, p. 8).

One participant regards the structure or setup of the service user as not conducive to recovery. They are putting the new admissions and readmissions together, which according to him, is not helpful. This assertion is explained in the extract below:

> [Setup of assisting people in rehabilitation centre is not good. They are mixing the new admission with the readmission in the same programme. How do they rehabilitate people who are addicted to drugs within six weeks? After that they discharged them to the same environment where the problem lies. It is a short period of time and things where not fixed in the community and at home.] (P3, M, 45 years)

Some authors concede that the readmissions and new admissions are not suited to attend the same programme. They understand that treatment plans must be reviewed often and modified to fit the changing needs of the service users (Volkow, 2019:2).

3.3.7.2 Subtheme 7.2: Inpatient treatment centres should eradicate the self-discharge policy.

Self-discharge means leaving the treatment centre without completing the programme or without any medical advice (Yusuf, Ogunlusi, Popoola, Ogunlayi, Babalola & Oluwadiya 2017, p. 174). As such, self- discharge disrupts the treatment therapies and is related to increased morbidity, mortality, readmissions, and increased healthcare expenditure (Yusuf et al., 2017, p. 174).

Treatment dropouts is one of the major problems encountered by rehabilitation centres (National Institute on Drug Abuse, 2018, p. 12). The participants and other family members are not happy about that, which is why they want rehabilitation centres to review their policy and change it, where possible, so that the service users cannot terminate their programmes early without no reason.

Some of the participants and other family members are not happy with the self-discharge policy and they want the rehabilitation centres to review their policy and change it where possible so that, the service users cannot be able to terminate their programmes early without no reason. Some of their views are included in the storylines below:

> [They must also change the policy that allow them to discharge themselves to make one that will make them to stay in the rehabilitation centre until completion of the programme.
>
> They must not allow them to discharge themselves before the programme is completed.] (P13, F, 48 years)
>
> [If they want to discharge themselves, they allow them. I will be happy if they can be denied self-discharge.] (P17, F, 57 years)
>
> [My view is that I wish there is contract and that contract be discussed with the service user before their discharged date so that they can take responsibility of themselves not being relapse. If they have a lot at stake since many people are affected negatively by their bad behaviour. They are going through a lot starting with the service user themselves, their family members, and the community. The exit model should be that when a service user is discharged, there must be a way of knowing where they are and whether the place is helping them … and whether they have something that occupy them during this time in their lives.] (P6, M, 46 years).

The findings seem to suggest that some service users are not committed to leaving drugs as they enter treatment and that it is only due to the pressure and efforts of participants and other family members that they go to a rehabilitation centre. They do not complete the treatment programmes because they were pushed to go there (Ferreira et al., 2015, p. 418). Some authors concede that the current policy of the self-discharge should be reviewed, as suggested by the participants, to alleviate morbidity and mortality as well as the negative effects on the families and neighbourhood (Groenewald & Bhana, 2016, p. 32). There is a need to address the concerns of the policy of self-discharge as well as to demonstrate a capacity to provide a remedy for the service users (Motsoeneng, 2018, p. 9).

3.3.7.3 Subtheme 7.3: Inpatient treatment centres should improve security and services.

One of the key issues is that the inpatient treatment centres must consider improving the quality of their services and security (Poor, Poor & Darkhaneh, 2013, p. 34). Thus,

the inpatient treatment services should meet the expectation of the participants, service users, other family members and the community (Poor et al, 2013, p. 36).

The participants complain about the security and services in the inpatient treatment centre. They are not happy about the way the staff are taking care of the service users. They feel that the supervision and monitoring of the service user are not done properly. This encourages the service users to use drugs because they know that they are not being watched. They suggest that the security must be improved so that they are able to monitor the movement of the service users. The participants' concerns are explained in the extracts below:

> [I wish that the officials can take good care of our children and make sure that they won't abscond. They must also make sure that the place is fenced properly, and that the children won't be able to jump the fence and go to smoke. They must be supervised so that they cannot go out for drugs. They must also ensure that they stay in the rehabilitation centre until they complete the programme without using drugs.] (P7, F, 54 years)

> [The security must be tight because the service user can use drugs while he is in the treatment centre. The staff are giving them drugs. I think if the security can be very strict things will be fine.] (P9, F, 29 years)

> [He even told us that, in the rehabilitation centre they can jump the fence and go out to smoke. A lot of things must be changed, even their security must be tight.] (P11, M, 37 years)

> [They should monitor our children so that they should not jump the fence and go and use drugs and thereafter go back to the rehabilitation centre.] (P13, F, 48 years)

> [The security must be tight so that there must be any visitors or care workers that would bring substances to the service users. The cameras must be installed so that they can be able to monitor what is happening in the rehabilitation centre.] (P12, F, 46 years)

Similarly, authors agree that the security system in inpatient treatment centres is poor and that there is no proper searching of service users and staff. This contributes to many service users being able to access drugs (Kheswa & Lobi, 2014, p. 617). Thus, the inpatient treatment centres must improve their security by developing an operational security centre department which will be in charge in monitoring incidents and providing an immediate response that can alert the care workers to be aware that something

strange is going to happen or is happening (Mendez-Giraido,Rodrigues-Garzon & Aranda-Rivera 2016, p. 7).The service users who have a history of using drugs require an inpatient management programme which improves the well-being of the service users and this must be monitored and supervised the whole day (Amoah & Charen, 2017, p. 1395). Improving the process security system allows the inpatient treatment centre to minimise possible risk to the organisation and this will assist in developing better services (Mendez – Giraldo, et al, 2016, p. 4).

3.3.7.4 Subtheme 7.4: Inpatient centres should offer better services.

Effective treatment attends to the wholeness of the service users, not just their drug addiction but anything that is related to that, including medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture (Volkow, 2018, p. 8).

The goal of treatment is to return service users to productive functioning in the family, workplace, and community. The treatment is aimed at providing help in the life of the service users during the process of recovery, and social integration when going back to the community (Bilici, Ogel, Bahadir, Machan, Orhan & Tuna, 2018, p. 150).

One participant is not happy about the work of the staff in the treatment centre. She believes that the staff are not working, which is why there is not better results affecting the treatment. She wished to see them improving their services. The assertation is explained in the extract below:

> [We want the staff to pull up their socks so that their work is good. We are taking our children in that treatment because we love them, and we also love the staff because they are assisting our children. But we realised that they are not pulling up their socks and they do not care whether the service users have left the centre on their own accord or opt for self -discharge. This makes us sad … But if they are not changing and try to work hard the services will not be improved. Without their good job the institution will be nothing]. (P8, F, 62 years)

The poor quality of the services that the staff render, is influenced by the institution not empowering, or providing training for the staff in relevant skills and knowledge (Monteiro et al., 2016, p. 5) that will allow them to work together effectively, such as effective communication, conflict resolution and problem-solving skills training which will allow

them to render better services (Monteiro, Lucchese, Vera, Felipe & Fernandes, 2016, p. 6). Moreover, the staff must use new technology, skilled labour, best practices, and education which will help them to increase the efficiencies in treatment centres (Osborne & Hammoud, 2017, p. 50).

Khalil & Adelabu (2017, p. 87) argues that it is not only the staff who must pull up their socks but also the managers, but they need to acquire new skills and knowledge in order to be effective. In turn, the managers will develop and train the staff and engage them in the change process to deliver efficient and effective services to the participants, the family members, and the service users.

One participant appreciates the importance of therapy for the whole family. She argues that it is not fruitful to focus only on the service users. This view is explained in the extract below:

> [They should not focus only on this person. They need to put us also in the programme that can make us to feel good. Sometimes what they will do is to focus only on the person who keeps on relapsing and left other family members.] (P2, F, 55 years)

Family therapy focuses on the whole family because if one family member is affected by drugs, this situation affects the whole family. That is why it is important to include other family members in therapy *(*Adzrago et al, 2018, p. 6*).*

Moreover, the use of a multidisciplinary team approach has been accepted as one of the best ways to deliver the services in treatment centres (Mohammadipour, 2018, p.32). The use of multidisciplinary teams in treatment centres restricts hostile proceedings, improves outcomes, and adds to patient and employee satisfaction. It includes all staff members from different levels (Epstein, 2014, p. 295).

One participant mentioned that the staff must work together to assists the well-being of the service user. The assertion is explained in the extract below*:*

> [I am thinking there is no working together among professionals that are rendering services to the client. Like as the care worker in the treatment setting are normally taking care of the client 24 hours, they must give feedback about the behaviour of the service user to the social worker and other professional must do the same because the social worker the one who is writing the report, or they must develop the multidisciplinary team

> where all the professionals come together to discuss about the service user, for example, care worker, psychologist, sister or nurse, social worker from outside and the social worker from the centre. They do not have that meeting in the centre.] (P6, M, 46 years)

Some authors concede that, for the treatment centre to render better services, they must work as a multidisciplinary team of professionals to help the service users to reach their goals and life plans physically, psychologically, socially, and educationally (Amoah & Charan, 2017, p.1393).

The importance of a multidisciplinary team is to involve the staff from different levels to work together with the same service user and each staff member will assist according to their professional limits without knowledge of each other's practice. They will be sharing a goal in using a common approach (Momsen, Rasmussen, Nielsen, Iversen & Lund 2012, p.911; Mohammadipour, 2018, p. 32).

3.3.8 Theme 8: Suggestions for social work services

3.3.8.1 Subtheme 8.1: Services required by relatives with recurring relapses.

The participants and other family members are experiencing difficulties in their lives because of the unchanged behaviour of the service user who keeps on relapsing. This affects the well-being of the participants and other family members who are around the service users. The stresses that families are experiencing because of the behaviour of the service users' drug addiction have been related to high psychological and physical morbidity, emotional distress, including feelings of shame, humiliation, blame and loss (Groenewald & Bhana, 2016, p. 2). This makes the participants come up with suggestions that they believe will help. The professional help that the service users need, such as counselling and readmission to the rehabilitation centre will be discussed here:

3.3.8.1.1 Subtheme 8.1.1: Counselling

Counselling is a special form of communication, and it has different aspects such as involving a relationship that is based on support. It is based on the principles of empowering people, based on confidentiality and it helps people to identify their own

resources (Viscu, 2013, p. 2). Counselling can be applied in many forms. It can take place

The participants believe that the social workers will offer counselling to the service users to help them in making the decision that will be fruitful in their future (Banerjee, 2020, p.128). They know that this intervention is going to control and make change in the life of the service users because they have the skills to creating an environment where service users will feel safe and this will make them comfortable/relaxed to express their feelings such as anger, pain and anxiety. This may lead them to personal and interpersonal growth (Kabir, 2017, p. 89). Most of the participants expressed a wish for their relatives to get counselling from the social worker as they believe that service users have some unresolved issues; hence, the reason they keep on relapsing. They believe that social workers are the relevant people to assist with counselling because they have the skills and qualifications. Their requests are expressed in the extracts below:

> [I want the social worker to assist him as soon as possible after he decides to quit drugs. South African National Council on Alcoholism and Drug Dependence takes long to assists. I want the social worker to assist him through counselling. They have got skills, maybe he can listen to them because he is not listening to us.] (P8, F, 62 years)
>
> [They must assist him to stop using drugs, so that he must behave before he started using them. The social worker can come and offer him counselling so that he can stop using drugs. He is not a bad person.] (P4, F, 63 years)
>
> [I think by offering him individual and group counselling group will assist.] (P12, F, 46 years)

Social workers can assist the service users' development by improving their personal effectiveness and skills like interpersonal relationships and addiction behaviours (Kabir, 2017, p. 24). Moreover, the findings seem to support the assertion that social workers are the relevant people to offer counselling because they are professionals and they are trained for that (Viscu, 2013, p. 1). Social workers can change the way service users view things and can help them in making the right decision. Their intervention will also assist the service users in remaining intuitive and positive in the future (Kabir, 2017, p. 84).

One participant believes that the death of the service user's father was the cause of the relapse. However, the service user did not open up to them about the issues he was experiencing. The participant believes that counselling will help him to express his feelings and to voice the issues that are haunting him. This assertion is explained in the extract below:

> [I want the social worker to offer him individual counselling sessions, maybe there is something that is bothering him that we do not know. Since the death of my father his behaviour changed, and he started joining friends that are using. We tried to ask him what is bothering him, but he does not say anything. I think that is the thing that affected him because he was very close with my father]. (P11, M, 37 years)

This finding emphasises the importance of the male parent (father) in the service user's life. The participant regards the death of the father as having a huge effect on the service users' life and it is very harmful to the service user because the father passed away during the child's early adolescence (Sahu & Sahu, 2012, p.17). Thus, they see the importance of the service user seeing a counsellor is because they believe the counsellor will assist the unhappy and unsuccessful service users who will identify their problems, and this will put the service user's life back on track (Banerjee, 2020, p.129).

3.3.8.1.2 Subtheme 8.1.2: Readmission of users into rehabilitation centres

The rehabilitation centre is the facility that that seeks to help the service users to recover from addiction caused by drugs (Amoah & Charan, 2017, p.1393). It helps the service users to achieve a normal state of health, psychological functioning, and social well-being to ensure their integration into their families and societies (Adzrago et al., 2018, p.1). Most of the time rehabilitation centres offer a programme that takes four to eight weeks. the rehabilitation process is a change for any service users hoping to free themselves from the chains of addiction (Ghazalli et al, 2017, p. 59)

The participants realise that it is important to keep the service users away from the environment where the addiction started, so that the service users can be treated from a place of isolation to avoid the environment where the addiction started. The need for rehabilitation was expressed in the following extracts:

> [To assist him in taking him to rehabilitation centre.] (P1, F, 26 years)

[I want the social worker to assist him to go back to a rehabilitation centre because he also wants assistance. I will be happy if he can get assistance.] (P5, F, 60 years)

[I want the social worker to take him to rehabilitation centre. Just tell me if he is going to rehabilitation centre, are you going to need clothes and toiletries.] (P7, F, 54 years)

[I like the social worker to prepare him before he goes to rehabilitation centre. So that he can be aware of what he is going to experience when he is at rehabilitation centre.]

[He must be willing to change and not get influenced by bad friends]. (P13, F, 48 years)

[I like the social worker to assist him to go back to rehabilitation centre. Maybe he will stop using.] (P14, F 64 years)

[I want the social worker to assist him by organising the forms for him so that he can be able to go to a rehabilitation centre again. I will be happy for that.] (P9, F, 29 years)

[I would like the social worker to assist him to go back to a rehabilitation centre. Maybe he will stop using drugs.] (P15, F. 67 years*)*

The findings seem to support the assertion that rehabilitation centres can help them to achieve the high level of functioning, indolence, and quality of their life (Amoah & Charan, 2017, p. 1393). Moreover, the service user can become calm and review their own lives and think about their future development, not while they are still under the influence of alcohol but when they are in the rehabilitation centre. Thus, the participants see that it is important for the service users to go back to the rehabilitation centre.

3.3.8.2 Subtheme 8.2: Services needed by participants.

The participants and other family members need professional support, that can empower them to deal with the situation they are facing. The professional help, that the participants need is counselling, food parcels and family therapy and this will be discussed below:

3.3.8.2.1 Subtheme 8.2.1: Counselling

The behaviour of the service users affected themselves, the participants and other family members in each segment of their growth and this issue needs the intervention of the social workers to change the painful life they are all going through (Lander et al., 2013, p. 8). The social worker will help the participants to understand the service users and to know their (the service users) weaknesses, strengths, abilities, and potentials that will make the participants able to assist the service users to adapt meaningfully to

their immediate environment (Yaumas, Syafril, Noor, Mahmud, Wekke & Rahau, 2018, p. 1197).

Some of the participants need professional counselling, because they are emotionally affected by the recurring relapses of the service users. This affects their sleep, and they are unable to share the difficulties they are experiencing within the community. The need for counselling was expressed in the following extracts:

> [I need counselling. I cannot sleep. I do not want to lie. I am thinking about my two children that are addicted to drugs. Yes, the other one is not staying with us]. (P14, F 64 years)

> [I want the social worker to assist me through counselling. Sometimes I ask myself that as a parent maybe there is something that I did not do well. I think there is something bad I did to them that is the reason they are on drugs. However, there is nothing bad I did to him, this behaviour is from the street. It is hurting, ma [madam], it is hurting, it is hurting [looking very sad]. It was better when he was alone, now his younger brother is also using. This is a heavy burden on me because I am the only one who is facing this situation. There is not a man in the house that I can share my problems with. … It is very painful I do not know how these drugs affect them because they are growing up and I do not know how their life will be in future. You see, yah! these are hurting me. We have seen on television that when they sniff this thing, they collapse, and blood comes from their nose, and they ended up dying. (P5, F, 60 years)

> … The main thing that is hurting is that, if research could be conducted on what they are using one may find that they are not using one drug because I am not with them when they smoke out there. They told me that it is dagga, but I do not trust them. Maybe even if you can interview them alone when I am not around maybe you can hear a lot that makes them to use the drugs I do not know.] (P5, F, 60 years)

> [I need counselling. Sometimes during the day, I can ask help from men in my community so that, they can talk to him. They will reprimand him because most of the time he is forcing me to give him money. He even steals some food in the house. The groceries that we bought while they are in the packet for example: washing powder we must take it out from the packet and put it in the container so that he must not be able to steal it. I am not buying groceries by bundles like other people because I only buy one thing at a time from the supermarket (P15, F. 67 years)

> I need counselling. I have lot of problems and there is no one to communicate with. If I have a mother even if she is blind, I will share my problems with her. I have siblings in Tembisa [township in the east of Gauteng under Ekurhuleni Metropolitan Municipality], but she does not have a good relationship with me. Even if you call her, she will not listen to you. She will say she does not have money, even the tenants did not pay even

though you do not want money. Even if you want to tell her your problems, she does not have time to listen for that. (P10, F, 64 years)

… The person whom I was sharing with her, my deepest problems, passed on. Currently I see myself as a lost person. I am always in the house when I go out it is the time when I go to the clinic. When I come back, I stay here. All the things that are bothering me I have bottled them inside. Today I am going to sleep because I did share a lot with you. During the week I was thinking about that friend of mine. I wish I could go to her grave and sit next to her head and communicate with her. She assisted me a lot when I was ill during the night she will wake up and cook and we will share our problems to each other the whole night. Her husband was also kind but other things you cannot share with men but with women.] (P10, F, 64 years)

[I want counselling. I do not know about others. He also needs counselling because since his parents passed on, he never got counselling.] (P17, F, 57 years)

The findings are supported that counselling will assist in changing the behaviour of the participants towards the service users, improving their coping skills, assisting them in making good decisions, improving the relationship between the participants and the service users (Kabir, 2017, p. 83). The participants believe that the social worker can help them to solve their own problems (Yaumas et al, 2018, p. 1197).

3.3.8.2.2 Subtheme 8.2.2: Services needed by families

Participants are struggling financially, and this makes them not able to meet certain needs in the house. They think that not having enough food in the house is the reason the service users are stealing food from their neighbours. Hence, the participants hope that if there is food in the house, there is a possibility that the service users will stop stealing from their neighbours and will stop using drugs.

Second, the participants were overwhelmed with multiple issues that were caused by the behaviour of the service user. Therefore, family therapy is needed to encourage them to focus on the ways that will help them to manage the behaviour of the service users.

Provide food parcels.

The families where there is insufficient income to meet items for survival qualify for food parcels (Gumede, 2021, p.188). This helps in reducing poverty and mitigating against

inequalities. The South African Social Assistance (SASSA) is the agency that plays an important part in the distribution of food assistance through vouchers and cash (Mudau, 2020, p. 365). SASSA (South African Social Assistance) programme is associated highly with poverty reduction.

One participant is getting a pension grant; however, it was not easy to meet all the requirements in the house. According to the participant, poverty is the other factor that makes the service user continue stealing from the community because he is hungry. The participant believes that if there is enough food in the house the service user will not go hungry, and this will make him stop stealing food. that is why she is requesting food parcels. This assertion is explained in the extract below:

> [If the social workers can assist us with sugar, maize, and other things, it will be better. This pension grant is not enough for the family needs. We also like good things. … If there is no food in the house, he plans to go and find them. The other day I left him alone in the house when I came back, I found him eating buns. I asked him where he got them. He told me that the lady who is staying on the same street with us gave it to him. I thought he is telling the truth because they like him. Later that day, he cooked meat, and I could smell it. I also asked him about it, and he told me that the same lady gave it to him.I started suspecting that he stole those things. I asked him if he stole those things he refused and told me that I can ask the lady. Few hours later the owner of the buns and meat came. You see, if there is no food in the house it is not good. We can suffer about lot of things, but children must have food in the house]. (P10, F, 64 years)

This extract supports that all human beings are entitled to live in dignity, free from hunger, food insecurity and malnutrition. This situation is linked to poverty; however, priority is given to the participants who meet the requirement (Mudau, 2020, p. 365). Most service users are unemployed, and this makes them get involved in criminal activities such as stealing foodstuff, which might be regarded as a buffer in alleviating distress (Kostadis & Papaioannou, 2017, p. 9). It was indicated that income level is linked to substance abuse. Low income in the family of service users is related to crime and substance abuse (Cheteni, Mah & Yobane, 2018, p. 12).

Family therapy

Family therapy has two purposes: It uses the strength and resources of the family to help them find a way to live without addiction (Menchak, Nuhu, Seth & Musa, 2020, p.

255). The participants believe that the whole family (the service users, participants, and other family members) needs counselling from the social worker. They believe that treating only the service users may limit the effectiveness of treatment for two main reasons: It leaves the stressing situation of the participants untreated, and it does not recognise the family as a source of support for change (Lander et al, 2013, p. 2); thus, participants believe that it is good for them also to get involved in therapy. Some of their views are expressed in the extracts below:

> [I think the social worker will assist in offering counselling, we [the whole family] really need counselling.] (P12, F, 46 years)

> [I think the whole family need counselling. We are not yet experienced with someone who is using drugs or substances. We need to be taught to know more about this problem. I think whatever we have said it will help a lot. In the first place about the brother self, he is focusing on negative things rather than positive one. At the same time, we are psychologically affected. So, we need to be assisted on being strong towards helping him and again I think more education is needed. I know that they do not have time, but whatever time they get, they must educate us, counsel us, and even help us.] (P3, M, 45 years)

> [The social worker should work with us as family members and also empower us in order to guide us on how to deal with these challenges because from my experience of 14 years being exposed to a person who is using drugs, it is not easy. It is a lifetime challenge so obviously me and other families of those who are using drugs need to be developed in a way that we can be able to cope with that situation and also how to protect that person. We need to restore them.] (P6, M, 46 years)

> [To do family therapy with us because we got hurt. My mother is worse than us. I hope it will assist her a lot maybe she will also be encouraged to go to the psychologists because when we told her to go, she refused. I have hope that we will be assisted and maybe my brother will also voice what is bothering him]. (P11, M, 37 years)

> [I think family therapy is needed. It is not only the brother who is struggling with this, as a family we are struggling. I think family therapy needs to be implemented and not only one session because we are really worried about him and then those worries will not only affect him. When we are affected, other people were also affected, then yes, I have learned that there are individual sessions groups, but I think ah! the community as well need to be taught because ah! a child cannot only be raised by a father and mom or a family. A community plays an important role, for instance, if there were many recreational activities, I think that will help a lot or the social worker would encourage the brother to make use of such facilities but there are none. I think social workers are the only ones that must advocate for the community to have those recreational facilities, or to have recreational activities which will be let by the social worker]. (P3, M, 45 years)

> [I do not know. As a family if we can get some workshop. The training can empower us on how to communicate with them. Sometimes the way we are communicating with them maybe we are pushing them away. Even in the house we are not behaving the same towards him. Some are calm, others are very angry to the extent that, you can see that they hate him. It will be good if as family members we can get training.] (P16, F, 36 years)

The findings support that, in difficult situations that they were unable to cope with, the social worker is needed to offer the participants therapy to deal with their troubles, and give them relief about the situation (Szapocznik & Hervis, 2020, p. 3) They were looking for treatment that will empower them so that they can manage and guide the service users to become productive people in their community (Szapocznik & Hervis, 2020, p. 3). The counsellors recognised that family therapy does not only focus on the service user but also on the participants and other family members, and that family involvement in treatment process serves as a crucial part of the recovery process for the service users (Johannessen, Nordfjærn & Geirdal, 2021, p. 2). Family therapy motivates the service users to feel a sense of family belonging and involvement in the maintenance of recovery because some service users get more depressed when their guardians do not visit them while those who are visited recover and faster and they also comply (Adzrago et al., 2018, p. 8).

3.3.8.2.3 Subtheme 8.2.3. Participants who do not need assistance

The family that can ensure proper management of their dynamic, can potentially strengthen and keep their resources to protect them from stressful situations. This is manifested through communication, which will promote positive-self-esteem among its members (Martinez-Montilla, et al., 2017, p. 594).

It may be concluded that some of the participants are coping, since they do not need social work services. They have developed coping strategies, such as different defence mechanisms.

However, Abadi and Amani (2015, p. 58) contend that this could be a way to compromise in a very painful situation and to pretend that it is not hurting them or that they are strong, and that the person does not feel pain, to regain their stability and

balance. Substance abuse is a stigmatised activity which makes the family develop stress and they might decide to keep quiet about the situation. The family may have decided to face the situation by engaging directly with the problem, tolerating the problem or by withdrawing from the service users (Casker, 2019, p. 24).

The participants explained that they are coping with the situation in which the service users are giving problems. They mentioned that they want the social worker only to assist the service users.

> [We are fine; we just want the social worker to assist my brother.] (P1, F, 26 years)
>
> [We are fine; we do not want the assistance of social worker. We want him to be assisted and be like other people who are successful in life. He must be a role model to his younger siblings]. (P13, F, 48 years)
>
> [I do not think there is a need.] (P9, F, 29 years)

The participants and other family members are using their own efforts to manage and to control the demands from their environment by regulating their unpleasant emotions and reacting in such a way that can alleviate the problem that is disturbing them (Choolabi, Sabet, Doostian & Azam & Farhoudian, 2015, p. 50). This should highlight that the strategies they are using play several functions in their lives, such as maintaining the internal conditions satisfactory for communication, promoting the independence and self-esteem of each member in the family and strengthening their relationship bonds and social support as well as monitoring the impact of situations and change in the family system (Martinez-Montilla, et al., 2017, p. 594).

3.4 CONCLUSION

This chapter presented the research findings derived from the semi-structured interviews with 17 participants who are the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. The biographical profile of participants was outlined in the first section, followed by eight themes and 23 subthemes, providing direct quotes from the transcribed interviews, and subjecting them to literature control. The first theme focused on that the participants suspected the cause to be the absence of their relative’s parents. The second theme focused on the

participants' feelings and reactions after discovering that their relatives continued to use drugs.

The third theme discussed the effects on the users' interpersonal relationships and the fourth theme discussed the effects of relatives' use of drugs on the family's well-being. The fifth theme represented the efforts by participants and the family to assist relatives who are relapsing, while the sixth them focused on the participants' coping mechanisms. The seventh theme focused on the participants' suggestions for the improvement of inpatient treatment programme. The chapter concluded at theme eight, which presented suggestions for social work services. The following chapter is the final chapter of the study which will include the summaries, conclusions, and recommendations.

CHAPTER 4

SUMMARIES, CONCLUSIONS, AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter is the final chapter in the study. It contains the summaries, conclusions and recommendations established from the research findings.

The goal of the study was to develop an in-depth understanding of the perceptions of significant others living with an adult family member experiencing reoccurring relapses in substance misuse. The goal is achieved because the researcher collected the data from the participants who have knowledge about the topic.

- The researcher explored and identified the perceptions of the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. This is also achieved because the researcher managed to gain the in-depth insight of the participants about the problem.
- The researcher described the perceptions of the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. This is also achieved because the participants were well managed to give more information about adult family member experiencing reoccurring relapse from substance misuse.

This chapter presents the summaries of three chapters: Chapters 1, 2, and 3. Conclusions and recommendation based on the research study are presented. Eight themes are presented from the findings of the 17 participants in the study.

4.2 SUMMARY OF THE PREVIOUS CHAPTERS

The study comprised four chapters. The previous three chapters are summarised as follows:

Chapter 1 provided a general introduction to the study. The background, problem statement, and rationale for the study were described,

the theoretical framework known as systems theory, has the following qualities: components, connections, structure, interactions, process holism and emergent properties, environment and identity. The research questions goals and objectives derived from the topic were presented.

The qualitative research approach was explained, followed by ethical considerations, such as informed consent, confidentiality, anonymity, and management of information, debriefing of participants, clarification of key concepts, and the structure and format of the study.

Chapter 2 offered a detailed description on how the application of the qualitative research process has gained from the understanding of the significant others of adult family members who have recurring relapses in substance abuse. The researcher followed certain elements when applying and describing the research process. She was able to choose the relevant research methodology that corresponded to the research study. This chapter also focused on how the research approach and designs were applied to the study. It gave detailed information on how the population was identified from the community and the purpose of identifying the population as well as how the sample was selected from the population. The chapter focused on how the data must be prepared before it can be collected. It explained how data verification and pilot testing, was going to be applied in the study.

Chapter 3 presented the discussion of the research findings emerging from the interviews of the 17 participants. The research findings were presented from the eight themes and subthemes that were analysed by the researcher, the supervisor and the independent coder, subject to a literature control.

4.3 CONCLUSIONS BASED ON THE RESEARCH PROCESS

The conclusions based on the outcomes of the qualitative research process are achieved and the ethical considerations are provided below. The researcher attended to the research questions; research goal and objectives; research approach; research design; and ethical considerations.

4.3.1 Research questions

A qualitative research approach was used to answer the research question of the study, namely:

- What are the perceptions of the significant others living with an adult family member experiencing reoccurring relapse from substance misuse?
- The research question was specific, relevant, and researchable concerning developing an in-depth understanding of the significant others who have an adult family member with recurring relapses in substance abuse. The research question was answered, based on the differences of experiences from the participants' perceptions concerning their frames of reference.

4.3.2 Research goals and objectives

The study had one goal, namely:

- To develop an in-depth understanding of the perceptions of significant others with an adult family member with reoccurring relapse in substance abuse.

The study goal was achieved, and it was presented in Chapter 3. The research objectives were achieved. They were indicated as follows:

- The researcher explored and identified the perceptions of the significant others whose adult family member has recurring relapses in substance abuse.
- The researcher described the perceptions of the significant others whose adult family member has recurring relapses in substance abuse.

4.3.3 Research approach

A qualitative research approach was employed to obtain the in-depth of the perceptions of the participants by exploring and describing them.

4.3.4 Research design

Exploratory, descriptive, contextual and phenomenological research designs were employed:

The exploratory research design assisted in exploring the experiences of participants about their adult family members who have recurring relapses.

The descriptive research design enabled the researcher to describe the participants' experiences in addressing their perceptions about the recurring relapses of their adult family members.

The contextual research design enabled the participants to share their experiences and their understanding influenced by their natural settings.

The researcher employed the **phenomenological design** because it focuses on the experiences of the participants regarding the phenomenon and their interpretations of that situation.

4.3.5 Ethical considerations

Ethical issues that were considered and attended to in order to protect the rights of the participants during the process of this research project will be discussed in the following subsections.

4.3.5.1 Informed consent

The researcher informed the participants about the purpose of the study before they were given the consent form. The following elements of consent were discussed with them.

- A detailed explanation of the purpose of the study;
- An indication of the approximate period of time it would take to complete the study;
- A description of what participants would be asked to do;

- A description of any foreseeable risks or discomforts that may be encountered during data collection;
- A description of direct benefits to the participants;
- A statement of the extent to which participants' confidential information will be protected; and
- A statement about the voluntary nature of participation.

4.3.5.2 Confidentiality

To ensure confidentiality, the information was kept between the researcher and the participants. Their identities were not revealed, as promised before the interviews. The interviews took place in the offices where the participants could feel free to participate.

4.3.5.3 Anonymity

The researcher followed the ethical considerations of anonymity during the collection of the data. The researcher protected the identities of the participants by using pseudonyms and their names were not linked to their pseudonyms. The researcher was the only one who could link the pseudonyms to their real names.

4.3.5.4 Management of information

The researcher followed ethical considerations to ensure that there was no harm by creating a password for the folder where the collected data and the information identifying the service user were kept.

4.3.5.5 Debriefing of participants

The researcher referred the participants who needed debriefing to the counsellor. They were also informed during the first meeting that they could stop at any time if they were feeling uncomfortable.

4.4 CONCLUSIONS BASED ON THE RESEARCH FINDINGS.

Conclusions drawn from the findings of the participants (significant others living with an adult family member experiencing reoccurring relapse from substance misuse.)

presented in the sections below, according to the participants' biographical profiles and themes.

4.4.1 Research findings of participants

The participants' biographical profiles reveal the following information:
There were 14 women and three men who participated in the study. Their ages range from 20 to 32. This indicates that the behaviour of the service users affects all age groups from the young to the elderly, ranging from 26 to 67. In this study most of the affected relatives were young. The participants mentioned the different levels of education of the service users. Only two service users had passed Grade 12, while 15 had less than matric and 14 participants do not have matric and only five have high educational level, two have national diplomas and three have university degrees.

4.4.1.1 Theme 1: Participants' understanding of the causes of their relatives' recurring relapses.

Participants mentioned a variety of factors which they understood to be the causes of their relatives' recurring relapses. Key amongst those factors are the following:

- They suspected the cause of the relapses to be the absence of the parents, either through death or neglect. Parental death or absence may have a negative influence on the development of the child.
- The participants recognized the important of a father and a mother in the life of service users. Mothers are recognised as powerful supports for the service users to recover. Also, sons whose fathers are involved in their life are less likely to use drugs.
- The participants realised that lack of motivation, goals and direction are also the factors that causes relapse. Direction helps in developing growth and maturity in the life of the service users, while goals help the service users to establish

direction and motivate them not to relapse. If they lack motivation, they will not maintain sobriety.

- The participants think about divine intervention for the service users because it will assist them to stop using drugs. Religion helps people to be organised and to be able to establish rituals, values, guidelines and a meaningful life.
- The participants also picked up that boredom and unemployment complement each other in causing the service users to relapse. If the service users are unemployed, they will be bored and may decide to use again.
- Service users are always in the company of friends who are using drugs as well. Service users have powerful connections that encourage them to spend most of their time together.

4.4.1.2 Theme 2: Participants' feelings and reactions after discovering that their relatives continued to use drugs.

- Participants feel pain and hurt about their relatives' drug use. The participants are experiencing emotional burden. They feel continuous pain and misery in their life, no longer experiencing peace and happiness since the addiction of service users.
- The participants were angry and disappointed about the unchanged behaviour of the service users.
- The participants were filled with pain and stressful. They tried everything to help the service user, but they failed, and this causes them to feel pain, and this is intense and long lasting.

4.4.1.3 Theme 3: Effects of addiction on the users' physical, mental and social well-being

- Addiction affected the service users mentally. It caused them memory impairment; their moods are unstable, and they behave strangely, like removing their clothes in public and laughing alone.
- It also has effects on the interpersonal relationships of the service users. It affected the relationships of the families, colleagues, and the community. The participants and other family members do not feel safe around the service users. The service users' moods are unstable. For instance, the service users are shouting and yelling and start fighting easily with participants and other family members.
- Addiction makes the service users engage in criminal behaviour to feed their addiction. The service users commit theft by stealing the belongings of the participants, neighbours and community. They also commit housebreaking with the intention to steal from the house, their neighbours and the community. This makes the family experience financial strain because they must use their money to replace the stolen goods for every person around them and for family members.

4.4.1.4 Theme 4: Effects of relatives' use of drug on the family's well-being

- Addiction affects the family health and well-being. It touches every member in the family. This situation affects the family, physically, psychologically, socially and emotionally.
- It also strained family relations. It causes the high risk of compromising and shattering the relationships in the family, and they might not be able to rebuild it again.

4.4.1.5 Theme 5: Efforts by participants and the family to assist relatives who are relapsing.

- The participants have taken the effort to assist the service users to stop using drugs. They still have the hope that the service user will change; thus, they encourage them to go to the rehabilitation centre. Furthermore, they keep on advising them about the dangers of using drugs and try to find out from the service user what pressing issues cause them to keep relapsing.
- The participants' involvement to assist relatives who are relapsing. The family members tried to involve service users in the household chores to show them that they are part of the family and that they still value them. The family members made hardened decisions towards the service users which impacted their relationships negatively without understanding that the service user have inconsistent symptoms. They also listened and gave advice to the service users.
- Service users' motivation to deal with addiction. Participants and family members motivate service users to quit drugs because they are worried about their future, health and income, and their legal issues.
- Service users are not motivated to stop using drugs because they rely on drugs to help them face their daily lives and to help them to deal and/or cope with particular feelings, thoughts and situations; hence, they are not motivated to change.

4.4.1.6 Theme 6: Participants' coping mechanisms.

- The participants and family members do not take the situation in the same way. Some can cope with the situation, while some cannot cope with it. Those who are coping with the situation did find a way to deal with the situation by reducing or preventing the stress that affects them negatively to protect themselves.
- Some participants are not coping with the situation, and they concluded that they need counselling. Counselling can empower them to acquire more skills so that

they can deal with the situation. Through counselling, the participants and other family members can share their problem with people who are experiencing the same problem because they feel that community is isolating them.

4.4.1.7 Theme 7: Participants' suggestions on the improvement of inpatient treatment programme

- Participants suggested that better services will improve the inpatient treatment programme.
- The extension of the service users' period of stay in the rehabilitation centre to develop skills. They expressed dissatisfaction about the period for which the service users are staying in the centre. They suggested that a suitable period would be one to two months or one year to two years.
- They also think that eradicating the self-discharge policy would improve the services. They want the policy to be reviewed and changed. They want to form part of the process.
- The security services should be improved. This will help them to monitor and supervise the service users not to use drugs in the centre. They want cameras to be installed, so that they can be informed immediately if the service users are misbehaving.
- Better services must also be offered so that the programme can be of a better standard. To achieve this, the staff must be trained to gain more skills and knowledge.

4.4.1.8 Theme 8: Suggestions for social work services

- The participants suggested the services required by the service users. They see that service users need counselling as it will empower them and assist them in identifying the resources that will help them not to relapse.
- The participants suggested that the service users must be readmitted. This will help them to be far away from the environment where they can access drugs easily. The rehabilitation centres are meant to free the service users who want to be clean from drugs.

- There are also services needed by the participants. They also need counselling so that they can face the situation they are in. They are unable to meet the requirements at home and they decided to ask for food parcels because they believe that, if there is food in the house, at least service users cannot relapse or go to the neighbours to steal food.
- The participants also suggested family therapy. They are not coping, so they see family therapy as important to them because it will offer them more knowledge on how to relate to the service users.

4.5 RECOMMENDATIONS

These recommendations are based on information from the significant others living with an adult family member experiencing reoccurring relapse from substance misuse. As the research has been done under the inpatient treatment centre, this recommendation will be useful to the Refilwe community and the inpatient treatment centre. The inpatient treatment centre will review the policy, educate the community about drugs, and about how to take care of addicted people. There are also recommendations for further and future research.

4.5.1 Recommendations for practice

- In view of the participants' assertion that the community is lacking the education or skills on how to relate or deal with addicted people**,** it is recommended that the social workers employed in the inpatient treatment centers
  and at NGOs should offer awareness campaigns to the community.
- The participants were of the view that the lack of facilities in the community, unemployment, and boredom are the cause of the service users continually relapsing. Therefore, it is recommended that the treatment centres implement the technical skills which the service users will learn during the time they spend in the treatment centres, so that when they get out of the centre they can use those skills in the community, or the treatment centres can connect them with companies that are implementing the same skills that they have learned so that they can offer them jobs.

Moreover, the social workers who are working with substance users must advocate the community to address their needs to the municipality so that, maybe they can create facilities in Refilwe where it will keep service users busy.

- Participants are of the view that they are unable to meet the requirements needed in their home; therefore, they see the best option is to ask for food parcels. It is recommended that the social worker working at treatment centres must refer the participants to the community developer to assist them to establish a project that will generate income because they need to be independent so that they do not rely on South African Social Security Agency.
- In view of the stigma and isolation that the relatives of the service users are suffering from the community, it is recommended that the social workers from tinpatient treatment centre and the NGOs who are working within the community must educate them to realise that the relatives are not at fault, so that they will relate well with them.
- Drug use and relapse seem to be a family disease which affects all members of the family. It is recommended that social workers should include other family members in their programmes.
- In view of strained family relationships, particularly between the service users and other family members, it is recommended that the social workers who are working.

  within the area of those families must offer family reunification services to mend the broken relationships.
- In view of the service users' criminal behaviour, it is recommended that social workers who are working at rehabilitation centres, probation officers, police officers, NGOs and social workers working at Secure Care should implement awareness campaigns about the consequences of crime.
- In view of the deteriorating health of the service users because they are not bathing, or eating well, it is recommended that nursing staff from the local clinics and from the rehabilitation centres should teach or educate the service users about the important of hygiene. This must also form part of the programmes in the treatment centres.

4.5.2 Recommendations for policy review

- In view of the participants' concerns about the self-discharge policy, it is recommended that the self-discharge policy be reviewed and amended and that the significant others who are staying with the affected relative must be involved.
- The participants suggested extending the period of the treatment programmes. They see six weeks as a too-short period for the service users, especially for those who have been into drugs for many years, for example, from three to ten years and more. Therefore, it is recommended that the authorities at the treatment centres extend the programme to six months and above.

4.5.3 Recommendations for education

- When the data was collected, the participants complained about poor service delivery to the service users, it is recommended that inpatient treatment centre be provided with trainings to be empowered so that, they will be able to render good service delivery.
- In view of the service users 'recurring relapse despite their families 'support, it is recommended that, the prevention programme be offered to the community to protect those who are not yet into drugs.

4.5.4 Recommendations for further and future research

- Considering that the health and well-being of most of the participants are affected, it is recommended that more qualitative studies be conducted on the health and well-being of the significant others whose family members have recurring relapses.

  In view of the participants' complaint about not having enough information about drugs, about how to assist the affected relative, and also about how to relate to them, it is recommended that more qualitative studies be conducted about how the significant other of affected relatives of substance abuse be assisted to gain more information on drugs, on how to assist the affected relative, and on how they can relate well to them.

4.6 CONCLUSION

This chapter presented the summaries and an overview of the qualitative research method, as presented in Chapter 3. A summary of the major research findings was presented according to the eight themes. This was followed by conclusions and recommendations based on the research findings. The discussion resulted in presenting recommendations for further research concerning practice, policy and education, and recommendations for future research.

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ADDENDA

ADDENDUM A: A LETTER REQUESTING THE INDIVIDUAL'S PARTICIPATION IN THE RESEARCH PROJECT

Dear Participant,

I, **Mercy Tlou Moloto**, invite you to participate in a research project entitled: Perceptions of the significant others whose adult family member has recurring relapses.

The purpose of the research is to develop an in-depth understanding of the perceptions of significant others with an adult family member with recurring relapses, with the aim of assisting social service professionals to improve their service rendering to the clients. The situation we are in now is not safe because of the COVID-19 virus. However, as a researcher, I am going to ensure safety and protective measures to you and to continue minimising the risk of being infected. For example, I am going to assess the risk benefit ratio to my research study as it requires face-to-face contact like the collecting of data in public spaces or in a location where social distancing cannot be practised. The preparation of the interview will be done individually, and I will wear a cloth face mask and have 70% sanitiser most of the time and I advise you to do the same. If you do not have this, please inform me in time (before any contact), so that I am able to assist.

We will also use online contact if that will be possible for you, and I will take care of the costs. However, if you can think of any suggestion how we can contact, do not be afraid to mention it to me. I can accept it but only if it abides by the rules of the university and it does not put either you or me at high risk. It is estimated that the interview will take approximately 45–60 minutes of your time. It will be in my office because it is big enough to allow social distancing as that is one of the requirements. Before making any contact, pre-screening will be done telephonically with you and there will be an attendance register that you are going to fill in, so that if there is any reason for you to

be traced you will be easy to be found. If you are not feeling comfortable to continue with the interview, you can terminate any time you like.

If you are feeling unwell you need not attend the interview and you must inform the researcher so that, the day for the interview can be rescheduled. This will also apply to the researcher, and you will be informed. (The interview will be cancelled and rescheduled for another day). Permission will be requested from you to use a tape recorder during the process of the interview, provided you have signed the consent form to participate in the study. You are advised to bring your own pen. If you will not bring your own pen, before I exchange my pen with you, I will wear disposable gloves for cleaning and disinfecting of the pen by using 70% alcohol sanitiser. The same will also apply before and after handing over the consent forms. The researcher will sanitise and you will also sanitise before receiving the consent form and after handing it over to me. Please provide me with an email if you have it, so that I can send the consent form to you through email. The surfaces and the resources that will be used during the interview will be sanitised and will be decontaminated before and after being used. Before the interview, your temperature is going to be measured. You will be asked the following pre-screening questions that were not included in telephonic pre-screening:

- Have you ever travelled overseas?
- Have you attended a funeral?
- Have you ever taken care of a person with COVID 19?
- Have you ever stayed under the same roof with a person affected by COVID 19?
- Have you ever been assessed for COVID 19?

Field notes will also be taken to record your responses. You will be asked the following questions:

- How old are you?
- What is your marital status?
- What level of education have you obtained?
- How are you related to the adult family member who repeatedly relapses?
- When was he/she admitted into the rehabilitation centre?

- How many times was he/she admitted?
- Did he/she ever get intervention for assistance?

The following questions will help the researcher to gather more in-depth information from you about the recurring relapses of your adult family member:

- Tell me more about the recurring relapses of your family member.
- Can you explain how these recurring relapses of your family member make you feel?
- Please share with me the challenges you are experiencing regarding the repeated relapses of your adult family member.
- What do you think motivates them to repeat this behaviour?
- What role did you play in assisting your family member who repeatedly relapses?
- How would you like to be assisted by professionals such as social workers?

The interview may open old wounds and, should that be the case, you will be referred for debriefing, with your consent, of course. Ultimately, the findings of the research will be presented to the departmental Research and Ethics Committee in the form of a report and will be published in a professional journal. I wish to emphasise that pseudonyms will be used to protect your confidentiality and anonymity. Please do not hesitate to ask for clarification on any matter relating to the study.

Thank you in advance.

Ms. M.T. Moloto

ADDENDUM B: RESEARCHER ACKNOWLEDGEMENT FORM

ACKNOWLEDGEMENT LETTER FROM HUMAN SCIENCES

THE COLLEGE OF HUMAN SCIENCES

RESEARCHER ACKNOWLEDGEMENT

Hereby, I, Mercy Tlou Moloto (ID number 7210140369081), in my personal capacity as a researcher, acknowledge that I am aware of and familiar with the stipulations and contents of the:

- UNISA Research Policy
- UNISA Ethics Policy
- UNISA IP Policy

And that I shall conform to and abide by these policy requirements.

SIGNED: 

Date: 28.04.2020

ADDENDUM C: CONSENT FORM

INFORMED CONSENT TO PARTICIPATE IN THE STUDY

I, ……, volunteer to participate in a research project conducted by Ms M.T. Moloto, a student from UNISA. I understand that the project is designed to gather information on the perceptions of the significant others whose adult family member has recurring relapses in substance abuse.

My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw from the study at any time without penalty. If, however, I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview immediately.

Participation involves being interviewed only by the student researcher from UNISA, as indicated above. The interview will last approximately 45–60 minutes. Notes will be written down during the interview. An audio recording of the interview and subsequent dialogue will be made. If I do not want to be taped, I will not be able to participate in the study.

I understand that the researcher will not identify me by my name in any reports or information obtained from this interview, and that my confidentiality as a participant in this study will remain secure. Subsequent uses of recordings and data will be subject to standard data use policies which protect my anonymity.

I understand that this research study has been reviewed and approved by the departmental Research and Ethics Committee and for research problems or questions, I may contact the following individuals:

Prof Kgadima	Researcher's supervisor	012 429 6515
Prof Williams	Research and Ethics Committee Chairperson	012 429 4269

I have read and I understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

…… **…..……**

Signature of participant **Date**

ADDENDUM D: INTERVIEW SCHEDULE

Biographical profiling questions:

The biographical questions are divided into the following:

Participant

- How old are you?
- What is your marital status?
- What level of education have you obtained?
- How are you related to the family member who relapses?

Family member who relapses.

- Age
- Gender
- How long has your family member been into drugs?
- How many times did he/she get admitted? /relapsed
- Education

Topic related questions

- Share with me about the recurring relapses of your family member (Prompts: When did she/he start using drugs? Which drugs? How did you realise that the person was using drugs?) Share with me your initial reaction when you realised that the person was using drugs.
- What is your view and experience about the recurring relapses of your family member? *(*Prompts: How it affects the person, what do you think encourages him/her to continue with his behaviour? Identify things that the significant other identifies as the cause of several relapsing*).*
- How was your reaction towards him/her after realising that she/he had relapsed? *(*Prompts: Emotions and behaviour towards the service user – the researcher will probe to find out the emotions and the behaviour that the significant others exposed to the service user after knowing about his/her relapse*)*
- How long did he/she stay sober before he/ she relapsed*? (*Prompts: focusing on the period before going back to drugs)

- Why does he/she keep on relapsing? *(*Prompts: trying to find out if the family member has some time with the service user to try to find out from him/her the reasons for keeping on relapsing, try to find out what bothers him/her, how can they assist(support) him/her to maintain his/ her sobriety and also try to find out if they are not failing him/her.
- What role did you or any other family member play in assisting your family member who keeps on relapsing? (Prompts: the researcher wants to know what kind of support the significant other gave to her/his family member)
- Based on experience, what things would you like to change regarding the inpatient treatment programme to prevent the recurring of relapses? (Prompts: to identify things that the significant others are not happy about regarding the treatment programme. What are the new things they want them to be implemented to stop recurring of relapse?)
- Please share with me the challenges you are experiencing regarding the repeated relapses of your adult family member. (Prompts*:* Explaining their experiences (Telling their story – the researcher will probe to find the experiences of the family in detail about the recurring relapses).
- How are you coping with the whole situation? (Prompts: What did you do before that failed? What are you doing currently to make sure that you will succeed and what did you do before that succeeded?).
- How would you like a social worker to assist individuals who relapse? (Prompts: focusing on intervention strategies).
- How would you like social workers to support/assist families of individuals who relapse?

ADDENDUM E: RISK ASSESSMENT TOOL

SECTION C: RISK ASSESMENT & CATERGORY

C1.1. HOW SHOULD THIS STUDY BE CHARACTERISED? (Please tick all appropriate boxes.)

Personal and social information collected directly from participants	**Yes**	X	No	
Participants to undergo physical examination*	Yes		**No**	**X**
Participants to undergo psychometric testing**	Yes		**No**	**X**
Identifiable information to be collected about people from available records (e.g., medical records, staff records, student records, etc.)	Yes		**No**	**X**

<u>Please note:</u> *For medical or related procedures, please submit an application to an accredited health research ethics committee. **Please add details on copyright issues related to standardised psychometric tests.

C 1.2 RISK ASSESSMENT CATEGORY

Guided by the information above, classify your research project based on the anticipated degree of risk. *[The applicant completes this section. The HSREC critically evaluates this benefit-risk analysis to protect participants' rights]*

Place an 'x' in the box provided

Category 1 **Negligible** No to indirect human participant involvement.		**Category 2** **Low risk** Direct human participant involvement. The only foreseeable risk of harm is the	**x**	**Category 3** **Medium risk** Direct human participant involvement. Research that poses a risk		**Category 4** **High risk** Direct human participant involvement. A real or foreseeable risk	

		potential for minor discomfort or inconvenience; thus, research that would not pose a risk above the everyday norm.		above the everyday norm, including physical, psychological and social risks. Steps can be taken to minimise the likelihood of the event occurring.		of harm including physical, psychological and social risk that may lead to a serious adverse event if not managed responsibly.	

(a) Briefly justify your choice/classification

The choice of a category 2 has been chosen because the participants were only asked to share about their experiences of the adult family member with recurring relapses in substance abuse.

b) In medium- and high-risk research, indicate the potential benefits of the study for the research participants and/or other entities.

This study will assist in developing new policies. This can empower social workers to improve their way of doing things and their therapeutic services will be more productive.

c) In medium- and high-risk research, indicate how the potential risks of harm will be mitigated by explaining to participants that the research process will sometimes evoke negative emotions in them. The researcher arranged counselling for the participants who were emotionally evoked. The researcher took the responsibility of arranging the debriefing for the participants as they were emotionally stressed. (see Addendum F). If a participant has been emotionally harmed, the researcher will prepare counselling for him/her. The participants were informed during their first meeting that they can stop at any time if they were feeling uncomfortable with the questions.

C1.3. DESCRIPTION OF STEPS TO BE UNDERTAKEN IN CASE OF ADVERSE EVENTS OR WHEN INJURY OR HARM IS EXPERIENCED BY POTENTIAL PARTICIPANTS ATTRIBUTABLE TO THEIR PARTICIPATION IN THE PROPOSED STUDY.

In case the participants experience psychological harm owing to unforeseen circumstances, the researcher restored the participants emotionally and those who showed signs of needing further counselling were referred to the social worker (Mr Shibambu) who accepted assisting them during that time. (See acceptance letter in Addendum H).

C1.4 WHAT IS THE AGE RANGE OF POTENTIAL PARTICIPANTS FOR THE PROPOSED STUDY?

26–67

C1.5 If the potential participants are 18 years and older, is the participants' informed consent form attached?

Yes	**X**	No	Not applicable

C1.6 If the proposed participants are younger than 18 years, are consent and assent forms attached? (In order for minors – younger than 18 years of age – to participate in a research study, parental or guardian permission must be obtained. For minors a youth assent form is required.)

Yes	No	Not applicable	**X**

C1.7 DESCRIPTION OF THE PROCESS FOR OBTAINING PARTICIPANTS' INFORMED CONSENT (IF APPLICABLE)

Participants were informed about the project. They were informed about the topic of the study, the aims, objective and the benefits of the study. The researcher informed the participants that it is voluntary to participate in the project. And it was explained to them that they will be no payment for participation. They were informed that they could withdraw from the study at any time without penalty. If, however, the participants feel uncomfortable in any way during the interview session, they were informed that they have the right to decline to answer any question or to end the interview immediately.

C1.8 DESCRIPTION AND/OR AMOUNTS OF COMPENSATION INCLUDING REIMBURSEMENTS, GIFTS OR SERVICES TO BE PROVIDED TO PARTICIPANTS (IF APPLICABLE) (Will potential participants incur financial costs by participating in the proposed study? Will there be any incentives to be given to potential participants for participation in this proposed study?)

No compensation or gifts are to be given to participants

ADDENDUM F: CONFIDENTIALITY AGREEMENT

CONSENT FORM REQUESTING PERMISSION TO PUBLISH INFORMATION

As part of this project, I have made an audio recording of you. I would like you to indicate (with ticks in the appropriate blocks next to each statement below) what uses of these recordings you are willing to consent to. This is completely up to you. I will use the recordings only in the ways that you agree to. Names will not be identified in any of these recordings. Place a tick [✓] next to the use of the recordings you consent to:

The recordings can be studied by the research team and the transcripts from the recordings can be used in the research report.	
The quotations from the transcripts of the recordings can be used for scientific publications and/or meetings.	
The written transcripts and/or recordings can be used by other researchers.	
The recordings and the transcripts of the recordings can be shown/used in public presentations to non-scientific groups.	
The recordings can be used on television or radio.	

…… **…..……**

Signature of participant **Date**

ADDENDUM G: REQUEST LETTER FOR DEBRIEFING SERVICES

Date: 30.10. 2019

For attention: Mr Eddie Shibambo

I, **Mercy Tlou Moloto,** the undersigned researcher, am a postgraduate student at UNISA. In partial fulfilment of the requirements for the master's degree, I have to undertake a research project and have consequently identified a need to investigate the following research topic: **Perception of the significant others living with adult family member experiencing recurring relapses in substance misuse: a social work perspective.**

I am hereby seeking your permission to refer the participants who need counselling/therapy to you. I will provide you with a copy of the approval letter, which I will receive from the University of South Africa Research Ethics Committee. For any further information, please do not hesitate to contact me using the following details: Cell number: 0827342141 or email: 31908121@mylife.unisa.ac.za

If you accept to assist with the above-mentioned debriefing sessions, please fill in the details underneath.

Thank you for your time and consideration in this matter.

Yours sincerely

Researcher: Mercy Tlou Moloto

Signature: 

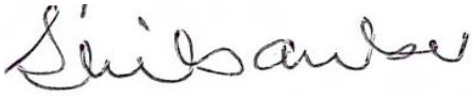
ADDENDUM H: ACCEPTANCE LETTER FROM DEBRIEFER

DEBRIEFER'S PERMISSIONS - ACCEPTANCE LETTER AND QUALIFICATION

ACCEPTANCE LETTER FOR DEBRIEFING SESSIONS

I, Mr Khazamula Eddie Shibambu, SACSSP number 1035066, a social worker at the Dr Fabian and Florence Ribeiro Treatment Centre, will assist with therapy to research participants when the need arises.

DATE: 30/10/2019

SIGNATURE: 

ADDENDUM J: ETHICS CLEARANCE

SOCIAL WORK RESEARCH ETHICS COMMITTEE (SWREC)

Date:29Julv2020

Dear Ms MT Moloto

DECISION:
Ethics approval from 28 July 2020 to 31 July 2021

SWREC Reference #: 2020-SWREC-31908128
Name: Ms MT Moloto
Student #: 31908128
Staff #:

Researcher(s): Name: Ms MT Moloto
Contact details: 31908128@mylife.unisa.ac.za; 0827342141
Name: Prof NP Kgadima
Supervisor(s): Contact details: kgadinp@unisa.ac.za, 012 429 6515

Titte of research:
Perceptions of the significant others living with adult family member experiencing reoccurring relapse in substance misuse: Social work perspective

Qualification: Master of Social Work (MSW)

Thank you for the application for research ethics clearance by the Social Work Research Ethics Committee
(SWREC) for the above-mentioned research. Ethics approval has been granted effective from 29 July 2020.

The following are standards requirements attached to all approval of all studies:

1. Approval will be for a period of twelve months from of the date of issue of the certificate. At the end of this period, if the study has been completed, abandoned, discontinued or not completed for any reason you are required to submit a report on the project. If you complete the work earlier that you had planned, you must submit a report as soon as the work is completed. Recoding template can be requested from the SWREC administrator on radebnl@unisa.ac.za
2. However, at the end of twelve months' period if the study is still current, you should instead submit an application for renewal of the approval.
3. Please remember that you must notify the committee in writing regarding any amendments to the study.
4. You must notify the committee immediately in the event of any adverse effects on participants or any unforeseen event that might affect continued ethical acceptability of the study.

GAUTENG PROVINCE
SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

5. At all times you are responsible for the ethical conduct of your research in accordance with the SWREC standard operating procedures, terms of references, National Health Research Council (NHREC) and university guidelines.
6. During data collection, ensure that you adhere to the UNISA COVIC-19 regulations.

Yours sincerely

.....

Dr KJ Malesa: Chairperson of SWREC
Email: mateskj@unisa.ac.za
Tel No.: (012) 429 4780

Enquiries: Dr. Sello Mokoena -ret:
082 331 0786
File no.: 01/07/20

Dear M Moloto

RE: APPLICATION TO CONDUCT RESEARCH IN THE GAUTENG DEPARTMENT OF SOCIAL DEVELOPMENT

Thank you for your application to conduct research within the Gauteng Department of Social Development.

Your application to conduct research on 'PERCEPTIONS OF THE SIGNIFICANT OTHERS WHOSE ADULT FAMILY MEMBER HAS REOCCURRING RELAPSE IN SUBSTANCE ABUSE: SOCIAL WORK PERSPECTIVE" has been considered and approved for support by the Depadment as it was found to be beneficial to the Departments vision and mission. The approval is subject to the Department's terms and conditions as stated on the GDSD application form.

You have permission to interview officials and beneficiaries within facilities regulated by the Department, conduct obsetvations and access relevant documents where necessary.

May I take this opportunity to wish you well on the journey you are about to embark on,
We look forward to a value adding research and a fruitful co-operation.

With thanks

Dr. Sello Mokoena
Director: Research and Policy Coordination

Date: 07/07/ZDZD

APPENDIX K: EDITING CERTIFICATE

Ricky Woods Academic Editing Services **Proofreading certificate**
Cell: +27 (0)83 3126310
Email: rickywoods604@gmail.com

To Whom it May Concern

University of South Africa

Editing of Dissertation

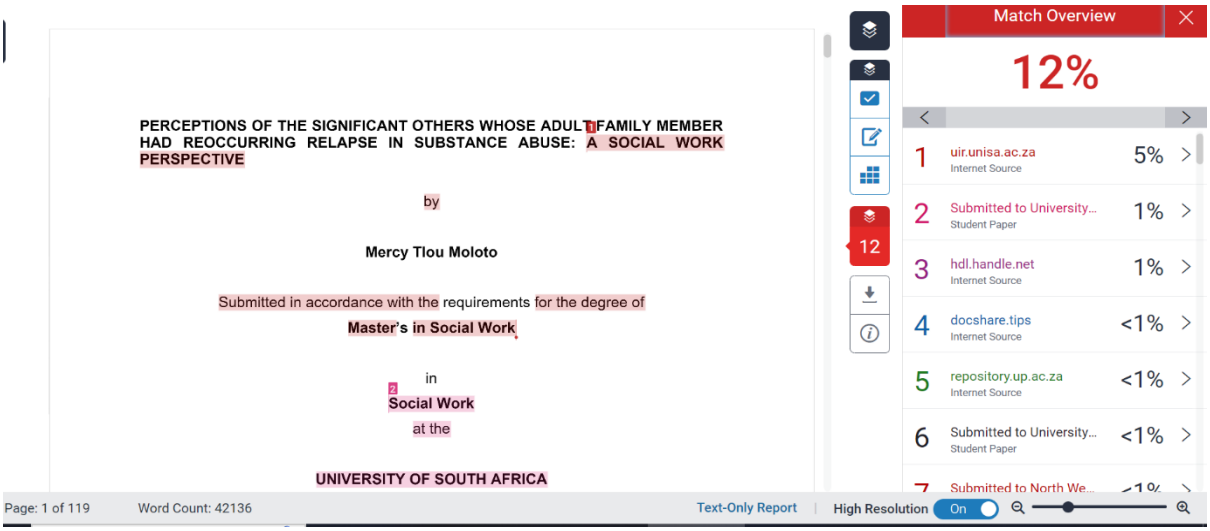
I, Marietjie Alfreda Woods, hereby certify that I have completed the editing and correction of the dissertation: **Perceptions of the significant others living with adult family member experiencing reocurring relapses in substance misuse: a social work perspective** by **Mercy Tlou Moloto,** submitted in fulfilment of the requirements of the degree **Master of Social Work** in the **Department of Social Work** at the **University of South Africa.** I believe that the dissertation meets with the grammatical and linguistic requirements for a document of this nature.

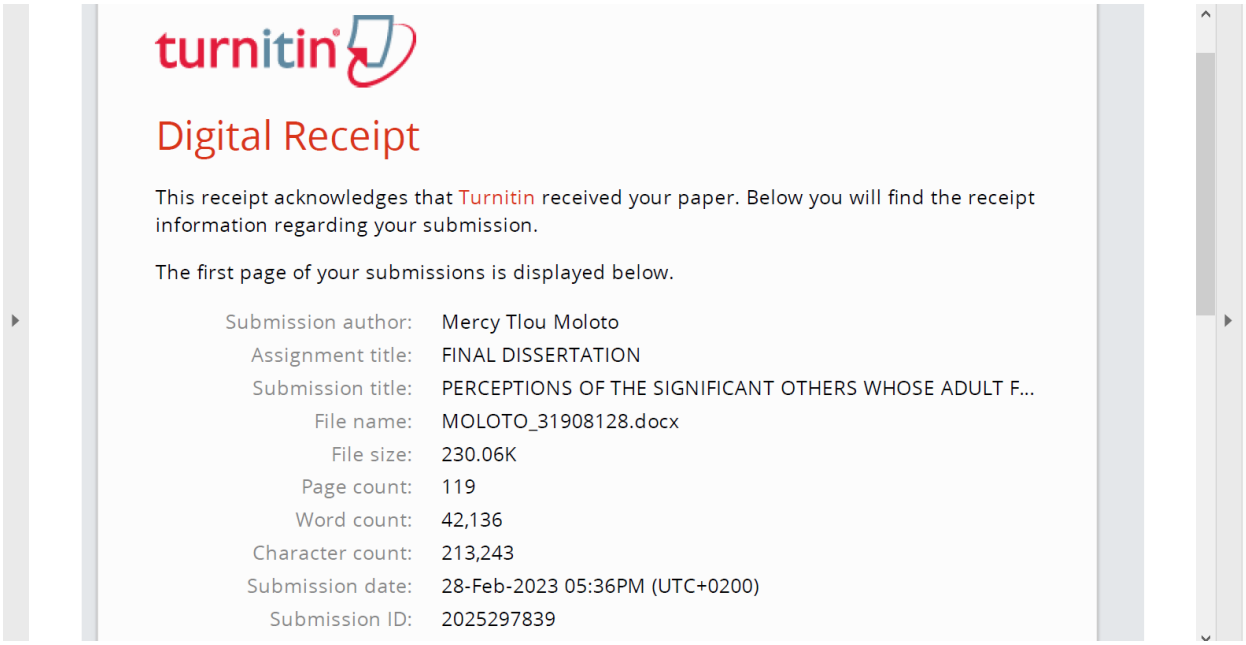
Name of Editor: Marietjie Alfreda (Ricky) Woods

Qualifications: BA (Hons) (Wits); Copy-editing and Proofreading (UCT); Editing Principles and Practice (UP); Accredited Text Editor (English) (PEG)

27 February 2023

ADDENDUM L: TURNITIN REPORT AND SIMILARITY INDEX





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Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	Mercy Tlou Moloto
Assignment title:	FINAL DISSERTATION
Submission title:	PERCEPTIONS OF THE SIGNIFICANT OTHERS WHOSE ADULT F...
File name:	MOLOTO_31908128.docx
File size:	230.06K
Page count:	119
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Character count:	213,243
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