



**THE PERCEPTIONS, EXPECTATIONS, FEARS
AND NEEDS OF CHEMICALLY DEPENDENT
YOUTH IN A REHABILITATION CENTRE
ABOUT BEING REINTEGRATED INTO THEIR
FAMILY SYSTEMS**

by

JEANETH LINKI MATSIMBI

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SUPERVISOR: PROFESSOR A. H. ALPASLAN

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Student Number: 3136-801-8

I declare that **THE PERCEPTIONS, EXPECTATIONS, FEARS AND NEEDS OF CHEMICALLY DEPENDENT YOUTH IN A REHABILITATION CENTRE ABOUT BEING REINTEGRATED INTO THEIR FAMILY SYSTEMS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

.....

Date:

SIGNATURE

(MRS J.L. MATSIMBI)

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ABSTRACT

Drug abuse is a very common problem these days; and this problem is especially rampant among the young people of South Africa. Early problems in family management, the antisocial behaviour of the child, and peer pressure and rejection ignite the early onset of substance abuse. Treatment programmes and therapeutic methods to treat chemical dependency are available and utilised, but the high relapse rate and lack of support from family members and dysfunctional families, as well as the fears and challenges expressed by in-patient youth about being reintegrated with their families and a lack of supporting literature in this regard remain a cause for concern and need to be considered by the social work profession in order to plan effective intervention strategies.

In response to this situation a research project was undertaken with the purpose of exploring and describing the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being integrated into their family systems in an attempt to forward recommendations to assist social workers in rendering effective therapeutic services to service users in rehabilitation centres who have a substance abuse problem.

A qualitative approach was utilised following an explorative, descriptive and contextual research design. The study was conducted at an in-patient rehabilitation centre called the Dr Fabian and Florence Ribeiro Treatment Centre in Cullinan, Gauteng Province in South Africa. Data were collected by means of semi-structured interviews. A sample of participants was selected by using purposive sampling from a population of service users in the Dr Fabian and Florence Ribeiro Centre who are chemically dependent. Data were analysed according to the framework provided by Tesch (cited in Creswell, 2003). Guba's model (cited in Krefting, 1991) was employed for data verification.

The research findings point to the fact that participants had both negative and positive perceptions about going back to their respective families. On the one hand, there were negative perceptions shared. These were founded on a feeling of worry about the fact that their families criticised them a lot or that their families would not accept that they had changed, would still treat them like addicts, and not trust them. Furthermore, they feared relapse, triggers in their environment and family members who were abusing a substance. On the other hand, some participants perceived the reintegration with their families, following treatment, in a positive light as they were looking forward to joining them again after being in

treatment for three months. They were excited about the fact that they had been granted an opportunity where they could show their families that they have changed and have the chance of starting a new life. Moreover, part of the research findings point to the fact that some of the participants' families had already organised employment, a place for them to stay and financial assistance. From the research findings it became clear that the participants harboured the following expectations towards the families with whom they were reuniting: They need the family's love and support; to trust them again; to mend severed relationships and spend quality time together; to provide practical and material help, and for the family to be educated on addiction and for the family to accompany them to aftercare. In terms of research findings directed at the site (i.e., the rehabilitation centre) where the research was conducted the participants indicated that they needed more activities, they would like their families to be part of their recovery process, and expressed the need for individual sessions apart from group sessions and aftercare services.

In terms of recommendations it was apparent that community members, community organisations and the government sector need to develop and launch chemical substance abuse prevention and awareness programmes through various media, (i.e. articles in newspapers, magazines, talks and documentaries on radio and television, community gatherings and meetings in all communities). Moreover, it is recommended that parents should take responsibility for monitoring and countering substance abuse in their children. Families need to be empowered through talks, attending parenting skills training, workshops and group meetings. South Africa needs to develop a policy focusing on families. Furthermore, it is recommended that treatment centres need to provide individual sessions, family therapy, aftercare services and more extramural activities, if these are not included in their treatment regime.

Key terms:

Chemically dependency; chemically dependent youth; family reintegration; residential treatment; chemically dependent youths' fears re integration; aftercare services; support needs; reintegration challenges; family dysfunction; chemically dependent youths' expectations re integration with their families.

LIST OF ABBREVIATIONS

DFRTC: Dr Fabian and Florence Ribeiro Treatment Centre

SANCA: South African National Council on Alcoholism and Drug Dependence

SACENDU: South African Community Epidemiology Network on Drug Use.

NGOs: Non-Governmental Organisations

CBOs: Community Based Organisations

FBOs: Faith Based organisations

UNISA: University of South Africa

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CHAPTER ONE

INTRODUCTION AND GENERAL ORIENTATION TO THE STUDY

In the section to follow, a general introduction and problem formulation will be presented, as well as the rationale for the study.

1.1 General introduction, problem formulation and rationale for the study

Substance abuse among the youth in South Africa is increasing at an alarming rate. This was confirmed by President Nelson Mandela in his opening address to Parliament in 1994 when he singled out substance abuse as a growing problem facing South Africa and needing to be combated (Drug Advisory Board, 1999:1). Alcohol and Drug Abuse Research Unit (2009:1) confirmed that most of the youth who use illegal drugs such as cannabis and other substances, will usually have first used alcohol and/or tobacco. According to South African National Council on Alcoholism and Drug Dependence's National Treatment Report (2009-2010:3) there was an increase of 47 clients younger than 13 years in the period 2008/2009. A total of 22% (2528) of the clients were younger than 17 years of age, which is an increase of 4% over the previous year. The trend is that young people abuse more than one substance. Although alcohol is a primary substance abuse, it has decreased 6% over the past five years to 44%. The highest number of clients with an alcohol dependency is 2417 in the age group of 36-59 years of age. The abuse of dagga showed a steady increase over the same period and is currently at 30%, with a sharp increase (1384 clients) in the age group of 14 to 17 years of age abusing this substance. Crack/cocaine use decreased by 3% to 4%, whilst heroin/opiates use increased by to 8% (255 clients) during the past year. This is followed by 750 clients with methamphetamine as a primary substance (7%) of whom 648 were from the Western Cape (South African National Council on Alcoholism and Drug Dependence's National Treatment Report, 2009-2010:5-6).

According to the South African Community Epidemiology Network on Drug Use (SACENDU), an increasing number of young patients are being admitted to rehabilitation centres for drug related problems. According to the report for May 2010, 46% of the patients admitted to treatment were younger than 25 years (South African Community Epidemiology Network on Drug Use, 2010(b):5). According to the United States Department of Justice

(Office of Justice Programs); and Office of Juvenile Justice and Delinquency Prevention (2004:1), substance abuse is still one of the most troubling problems facing the nation's youth. Although recent surveys document some encouraging trends, far too many young people still participate in the dangerous gamble of using drugs. The 2002 National Survey on Drug Use and Health in the United States found that almost 31% of youth aged 12—17 had used an illicit drug at some point in their lives, 22% in the last year, and more than 11% in the last month. The survey also found that 37% of youth had used tobacco (24% in the last year, and 15% in the last month). Alcohol use was even more common: 43% (with 55% in the last year, 18% in the last month). For all young people, not only does substance abuse carry significant health risks, but it can also be associated with serious – and often devastating – social problems such as crime and violence, scholastic problems, accidents and injury, risky sexual behavior, and mental and physical problems (Alcohol and Drug Abuse Research Unit, 2009:1).

Substance abuse amongst the youth does not happen in a vacuum, but in a diverse social context which comprises a number of factors, of which the United Office on Drugs and Crime in South Africa outlines several risk factors that are associated with substance abuse among the youth such as being young, male, with poor personal and social skills as well as family factors including amongst others family disruption, ineffective supervision, criminality and drug use. Risk is involved if a young person is homeless or does not have a secure family environment. The risk is also common if the family does not take care of the youth emotionally or physically, or does not provide appropriate support and guidance. There is more risk if the young person is being abused mentally, physically or sexually (United Nations Office on Drugs and Crime, 2004:5). According to Hostetler and Fisher (1997:398-399), these factors span the multiple domains of the individual, the family, the school, the peer group, and the neighborhood/community/society. Several characteristics of the parent-child relationship have been found to be related to substance use, including authoritarian discipline, lack of monitoring, and poor communication. Communication problems, not only between parent and child, but often between parents as well, characterize the families of substance users. As a result of all these factors, school performance is often affected. Weak religious values and low participation in religious activities have been indicative to substance use (United Nations Office on Drugs and Crime, 2004:5 & 11). Not only does the former ignite and maintain substance abuse among the youth but also compromises their sobriety following treatment and induces relapses.

The following are identified as risk factors contributing to relapse in youth who are chemically dependent: anger and frustration, stress, social pressure, social control, poverty and poor parental involvement (Brand & Delpont, 2005:170; Fraser, 2002:121; Goodwin 200:76). Substance abuse can be a normal practice within a subculture where there is a rejection of the usual rules of society (Goodman, 2007:5). According to Goodman (2007:26), substance misuse does not occur in isolation and is often associated with other problems such as truancy, school exclusion or family problems.

On a national level, a report on the 1st Biennial Substance Abuse Summit (National Department of Social Development 2007:2) asserts that more statistics and research are needed in order to improve services related to substance abuse among South African schoolchildren. Such services will include amongst others rehabilitation centres where a youth is committed for a certain period of time. The treatment period for chemically addicted adolescent in rehabilitation centres should be long enough to be effective in producing positive change (Van der Westhuizen, 2007:5). It is during this time that young people need all the support they can get from the family to deal with emotions associated with incarceration. Isaacson (in Ashdown, 2006:38) asserts that the basic emotions associated with the adolescent drug abuser in rehabilitation although rarely expressed, are loneliness, shame, guilt, a need to belong and be accepted, anger and depression. If these feelings are not allowed expression in the family, the adolescent will most likely relapse after release and continue to abuse substances. Youth in rehabilitation centres often feel that they disappointed their parents or have stigmatised the family. This results (as indicated above) in feelings of shame and guilt. For a young person to be committed to a rehabilitation centre means that he/she is unable to break the cycle of cravings and therefore cannot quit by themselves. To some this signifies defeat and helplessness. Through dedication, determination and a strong support network, youth who battle with alcohol and drug dependency can be completely healed and empowered to get on with their lives. This means with commitment to treatment, a young person can be successfully reintegrated back into the family of origin. However, it is normal for the young person to display fears and doubts about going home after being in a controlled environment which is drug free and problem free (Olszewski, Giraudon, Hedrich & Montanari, 2009:8 and Friedemann & Musgrove, 1994:no page number).

Historically, South Africa has not had very reliable systems in place to facilitate the collection of data relating to substance use. To date, much of the available information has come from *ad hoc* cross-sectional research studies conducted by the Medical Research

Council (MRC), the Human Sciences Research Council (HSRC) or the Council for Scientific and Industrial Research (Perry, 1998:3). This was confirmed by the researcher who after conducting a review of the literature on the topic under investigation learned that literature on the perceptions of chemically dependent youth in terms of support needs, expectations, and fears about reintegration into the family system after a rehabilitation programme was lacking. It is for this reason that the researcher identified a need for further research on what actually occurs when a young person goes back home in terms of expectations, fears, and perceptions. It was therefore concluded that there is indeed a need for qualitative research in order to broaden and deepen the understanding of the experiences, fears and needs of chemically dependent youth after a rehabilitation programme and also to assist social workers in identifying aftercare needs and a holistic in-patient treatment programme for the youth.

1.2 Problem statement

The research problem is defined as the general or substantive area of focus for the research and it begins with identifying an area of interest and generating ideas for the study (Strauss & Corbin, 1998:35; De Vos, Strydom, Fouché & Delpont, 2007:100). The researcher attempted to generate ideas when formulating the research problem.

The **problem statement** for this research was expressed as follows: Drug abuse is a very common problem these days; and this problem is especially rampant among the young people of South Africa. According Hostetler and Fisher (1997:398-399), early problems in family management, the antisocial behaviour of the child, and peer rejection have effects on the early onset of substance abuse. Treatment programmes and therapeutic methods to treat chemical dependency are available and utilised, but the high relapse rate and lack of support from family members and dysfunctional families, as well as the verbalised fears and challenges expressed by in-patient youth about being reintegrated with their families remain a cause for concern (Hammerbacher & Lyvers, 2006:387; Gruber, Fleetwood & Herring, 2001:267). Social work intervention forms part of treatment programmes at in-patient treatment centres. Therefore, social workers should be able to identify fears and expectations of the youth about being reintegrated back into their family fold upon completion of in-patients' treatment and their needs in this regard.

To sum up, the researcher embarked on this research project with the goal of developing an in-depth understanding of the perceptions, expectations, fears and support needs of the youth after an in-patient treatment programme in terms of being reunified with their families.

1.3 Reasons/Rationale for research

The researcher was working as a social worker at the Dr Fabian and Florence Ribeiro Treatment Centre¹, an in-patient treatment centre for chemically dependent clients/service users, in Cullinan. She worked as a therapist with service users who present with chemically dependent problems. The service users are admitted to the centre for a period of three months. During the three month period they go through a structured rehabilitation programme which is facilitated by social workers, social auxiliary workers, an occupational therapist and medical staff. Each service user is assigned to a social worker for a period of three months. The social worker is expected to work with this service user by conducting individual therapeutic sessions and group sessions. During this treatment period the service users are allowed to go for three days' therapeutic leave if they are from Gauteng province and for five days if they are from another province, when they have completed two months of their three month-treatment programme. On their return from this period of leave with their families, the services users share their experiences with the members of the multi-disciplinary team which establishes whether there are family problems such as co-dependency, lack of trust, lack of support and unrealistic expectations from family members about their recovery which could complicate their integration back into the family and which in turn feeds into a lack of confidence in and fear of relapse amongst the service users. In this researcher's experience these presenting complaints are frequent occurrences and therefore challenge one to look deeper into the perceptions, expectations, and fears of chemically dependent youth about reintegration back into their family system and their support needs in this regard. The lack of information on the reintegration of chemically dependent youth from a rehabilitation centre back into the family systems and the perceptions of the youth themselves serves as the rationale for the study.

¹Hereafter referred to as the DFFRTC

1.4 Research question

A research question is referred to as a specific query to be addressed by research that sets the parameters of the project and suggests the method to be used for data gathering and analysis (Strauss and Corbin, 1998:35).

The research question is important because it determines to a large extent the research methods that are used to answer it, and as such will help the researcher to choose an appropriate research method/approach (Strauss & Corbin, 1998:39)

The question for the intended research study was as follows: *What are the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system?*

1.5 Goal and the objectives

According to Fouché and De Vos (in De Vos et al., 2007:104) a goal/aim is referred to as the broader, more abstract conception of “the end towards which effort or ambition is directed”.

The goal for the proposed study was as follows: *To gain an in-depth understanding of the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system.*

The concept “objectives” is defined as the steps one has to take one by one realistically at grass roots level within a certain time span (Fouché & De Vos in De Vos et al., 2007:104). According to Brink (2006:79), a research objective should be a clear, concise, declarative statement that is written in the present tense.

In order to assist the process of realising the aforementioned goal, the following objectives were formulated:

- To obtain a sample of service users aged 18 – 35 years old at DFFRTC who have two weeks left to complete their in-patient treatment programme

- To conduct in-depth semi-structured interviews to explore the perceptions, expectations, fears and needs of these chemically dependent youth in a rehabilitation centre about being reintegrated into their family system.
- To sift, sort and analyse the data obtained using the eight steps of Tesch cited Creswell (2003).
- To subsequently describe the perceptions, expectations, fears and needs of these chemically dependent youth in a rehabilitation centre about being reintegrated into their family system.
- To undertake a literature control to verify the data.
- To draw conclusions and make recommendations to social workers and the family systems on how to prepare chemically dependent youth for reintegration with their families and support them in being reintegrated with their families.

1.6 Research methodology

Under this subheading the intended research approach and design to be followed in the research endeavour are presented.

1.6.1 Qualitative research approach

The research approach adopted for investigating the topic under discussion was a qualitative research approach. Qualitative research refers to any type of research that produces findings not arrived at by statistical procedures or other means of quantification. It can refer to research about person's lives, lived experiences, behaviours or emotions and feelings as well as about organizational functioning, social movements, cultural phenomena and interaction between populations (Strauss & Corbin, 1998:10-11). According to Kayrooz & Trevitt (2005:110), qualitative research is defined as a text-based or non-mathematical analysis and interpretation of information as it aims to identify the "who, what, when, why" and "how" of certain phenomena.

The following aspects are characteristic of qualitative research:

- ❖ Qualitative research is person centred as it views the world through the eyes of the participants and attempts to understand their perspectives, beliefs and history in their own contexts (Babbie & Mouton, 2001:271)
- ❖ Qualitative research attempts always to study human action from the insider's perspective on social actions, this is referred to as the "emic perspective" (Babbie & Mouton, 2001:53 & 271).
- ❖ The research process is inductive in nature as it begins with an interest in the natural setting, describing events as accurately as possible as they occur and slowly building a hypothesis or drawing conclusions based on the findings (Babbie & Mouton, 2001:273)
- ❖ This approach enables a researcher to get close to an individual perspective because it allows the researcher to become immersed in the details and specifics of the data (Kayrooz & Trevitt, 2005:110).
- ❖ Qualitative research is conducted in the natural setting of social actors (Babbie & Mouton, 2001:270).
- ❖ Qualitative research enables the researcher to learn the actions of the research participants in great detail and attempt to understand these actions in terms of the actors' own beliefs, history and context (Babbie & Mouton, 2001:270-271).

The qualitative research approach appeared to be suitable for this research as it enabled the researcher to seek and acquire a more grounded understanding of what are the participants' perceptions, expectations, fears, and needs and the meaning they attach to the event of returning home to their family systems after being in an in-patient rehabilitation centre.

1.6.2 Research design

The concept "research design" refers to the plan or blueprint of how one intends conducting research (Babbie & Mouton, 2001:74). In this research project the researcher proposed to use an explorative, descriptive and contextual research design.

An explorative research design, according to Bless and Higson-Smith (1995:42) and Fouché and De Vos (in De Vos et al., 2007:106) is conducted to gain insight into a situation, phenomenon, community or individual. The need for such a study could arise out of a lack of

basic information on a new area of interest or in order to get acquainted with a situation, in order to formulate a problem or hypothesis. Brink (2006:202) states that explorative research is conducted when little is known about the phenomenon that is being studied. In view of the fact that not much is known about the research topic, the researcher decided to use the explorative design for the purpose of exploring the perceptions, expectations, fears and needs of chemically dependent youth who are in a rehabilitation centre, are due to complete their three months' treatment programme and ready to go back home to their families.

A descriptive research design presents a picture of specific details of a situation, social setting or relationship, and focuses on why and how questions (De Vos in De Vos et al., 2005:106). This research design is used in studies where information is required in a particular field through the provision of a picture of the phenomenon as it occurs naturally (Brink, 2006:102). The descriptive research design was also used in this research as it enabled the researcher to describe in detail the perceptions, expectations, fears and needs of chemically dependent youth who are in a rehabilitation centre and due to complete their treatment programme and go back home to their families after three months in a rehabilitation centre.

The **contextual design** seeks to gather evidence of participants' perceptions according to the large context in which they occurred (Kayrooz & Trevitt, 2005:10). According to Babbie and Mouton (2001:272), the concept "contextual" refers to the understanding of events against the background of the context and how such a context gives meaning to the events concerned. In this research, the researcher's intention was to explore and describe the chemically dependent youths' perceptions, fears and needs from the context of being reintegrated back into their family systems.

1.6.3 Population, sampling and sampling techniques

The concept "**population**" is defined as the entire group of persons or objects that is of interest to the researcher or in other words that meets the criteria in which the researcher is interested (Brink, 1996:132). The population of this study comprised all youth service users (ages 18 – 35 years old) of DFFRTC who are left with two weeks to complete their in-patient treatment programme. The timeframe mentioned was considered suitable as the service users would have been back from their therapeutic leave and that is when they start realising that

the time to go home has arrived and they start displaying fears, doubts about going home after being in a controlled environment which is drug and problem free.

Sampling refers to a process of selecting individuals from the entire population in order to obtain information regarding a phenomenon in such a way that the findings reflect the concerns of the population of interest (Brink, 1996:133). According to Denzin and Lincoln (in De Vos et al., 2005:194), qualitative researchers seek out individuals, groups and settings where the specific processes being studied are more likely to occur. In view of this, the qualitative researcher tends to choose participants purposively through the use of purposive sampling. This sampling is used when the researcher chooses a sample on the basis of knowledge of the population, its elements and the nature of the research aim (Babbie & Mouton, 2001:166). This sampling technique was used to find a sample of youth who are in DFFRTC who have a chemical dependency problem and who fitted the following criteria of inclusion:

- ❖ Youth service users (18-35 years of age) who have been admitted for three months to a rehabilitation centre and who are left with two weeks to complete the treatment programme before being reintegrated with their families.
- ❖ Dependency on substances such as depressants (e.g. opiates, alcohol, barbiturates and benzodiazepines); stimulants (e.g. amphetamines, cocaine) and hallucinogens (e.g. dagga and lysergic acid diethylamide).
- ❖ Service users who were able to converse in English/Tswana/Tsonga as the researcher is able to speak and understand these languages.
- ❖ Service users who were willing to participate.

A specific sample size cannot be determined at the outset of the study, but the number of participants to be included in the sample can only be known once the data have reached a point of “saturation”, that is when the information being gathered becomes repetitive (Donalek & Soldwisch, 2004:356 and Brink, 2006:136).

In order to obtain a sample, the researcher first obtained permission to do research from the Department of Health and Social Development and further requested permission from the management of DFFRTC. After she had obtained such permission she contacted the case managers (Social Workers) for the youth in order to obtain more information about when they were due to be discharged from the Centre and whether they met the criteria to be

included in the study. The researcher then contacted the service users who met the inclusion criteria by making appointments with them through the case manager. During these contacts, with each of them on an individual basis, she introduced herself to the potential participants. She explained the purpose and the procedures of the research and also determined their willingness to participate in the research. The researcher provided the potential participants with the questions to be asked. Furthermore, she requested their permission to audio-tape the interviews. Where they decided to voluntarily participate in the research, they were requested to sign the consent form (see Addendum B). A follow-up appointment was made for the data to be collected at the Social Workers' offices in the Centre at a time most convenient to them.

1.6.4 Method of data collection

Under this subheading the following aspects will be presented: preparation for data collection, method of data collection, role of the researcher and pilot study.

Preparation for data collection: The researcher began the process of data collection by making contact with the participants who were service users at DFFRTC who were left with two weeks to complete their treatment programme. The purpose of this contact making was to request the participants to take part in the study. Furthermore, the criteria for inclusion were explained and it was pointed out to them that their participation in the study was voluntary and that they had a right to refuse to participate in the study, this would not affect their treatment programme at the Centre in any way and they would not be discriminated against because they refused to participate in the study. Those who agreed to participate in the study were prepared by having the consent form (Addendum A and B) explained to them. After they showed understanding of the consent form they were requested to sign the consent form. A follow-up appointment was made for the semi-structured interviews to be conducted in Setswana, English and Tsonga at the Social Work offices in the Centre at a time that would be most convenient to them. Lists of the questions to be posed to them during the contact were given to them in view of preparing themselves for this interview.

Method of data collection: For the purpose of collecting the data on the topic under investigation the researcher used **semi-structured interviews**. A semi-structured interview is a method of qualitative data collection that is used by the researcher to gain a detailed picture of the participants' beliefs about or perceptions or accounts of a particular topic

(Greef in De Vos et al., 2005:296). This method gives the researcher and the participants the opportunity to be flexible. The participants are perceived to be the “experts” on the subject and are given maximum opportunity tell their stories (Greef in De Vos et al., 2005:296-297). The researcher during the interviewing asked open-ended questions about their perceptions, expectations, fears and needs as they were about to exit the rehabilitation centre to join their families. The semi-structured interviews were digitally recorded and the participants’ permission to do so was sought. The questions were formulated in English and were translated into Setswana and Tsonga where necessary. The interviews were conducted in the social work offices at the DFFRTC.

The following questions were employed in this study for obtaining biographical particulars from the participants:

- ❖ How old are you?
- ❖ What is your gender?
- ❖ What is your race?
- ❖ Where do you stay?
- ❖ What is your employment status?
- ❖ First admission or readmission?
- ❖ Type of substance used?

With a view to gathering information about the topic under investigation the following questions were posed:

- ❖ How can your family assist you with your integration back into the family system?
- ❖ What are your perceptions about going back to your family?
- ❖ What are your expectations of your family members after completing the treatment?
- ❖ What are your fears about going back to your family?
- ❖ What excites you about going back to your family (being reintegrated)?
- ❖ What do you perceive to be your challenges when you are reunited with your family?
- ❖ What do you need (or your needs) in order to be reintegrated with your family?
- ❖ How can the rehabilitation centre support you in respect of successful integration with your family?
- ❖ How can the Centre and Social Workers assist you in terms of reintegration with your family?
- ❖ What do you think will make reintegration with the family easier for you?

Role of the researcher: According to Lofland and Lofland (in Babbie & Mouton, 2001:290), the role of the researcher in individual interviews allows her to find it socially acceptable to be incompetent when interviewing, this means that the researcher should be like a person who does not understand the situation he/she find him/herself in and must be helped to grasp even the most basic and obvious aspects of a situation. In this study the participants were regarded as the experts in their situations and the researcher was a “student” listening attentively and using the communication skills listed below.

The researcher will employ the following **interview techniques** in order to build trust and enhance communication during the interview: Listening, probing, clarification, focusing, empathy and encouragement (Mack, Woodsong, MacQueen, Guest & Namey, 2005:29; Egan, 2002:95-148; Du Toit, Grobler, Schenck, 1998:130-141).

Pilot study: A **pilot study** is normally relevant to determine the validity and reliability of the measuring instrument. Leedy and Ormrod (2005:152) advise that a pilot study should be done to ensure that the participants are able to answer the research questions. A pilot study was conducted with the first participant to provide the researcher with a trial run in qualitative interviewing and to see if the method of data collection and the data collection instrument enabled her to collect the data required.

1.6.5 Method of data analysis

Data analysis is defined as all forms of analysing data gathered using qualitative techniques (Babbie & Mouton, 2001:490). According to Marshall and Rossman (quoted by De Vos in De Vos et al., 2005:333), data analysis is a process of bringing order and structure to the mass of collected data. The purpose of data analysis in this study was to bring about an understanding of perceptions, expectations, fears and needs of young people being reintegrated into their family after in-patient treatment at the centre for being chemically dependent. The services of an independent coder were employed to analyse the data independently from the researcher. Upon completion of this process a consensus discussion was conducted, focusing on the themes and sub-themes that emerged from these processes of data analysis.

In this study the researcher employed the following eight steps as proposed by Tesch (cited in Creswell, 2003:192) to analyse data:

- ❖ The researcher read the entire transcript in order to get a sense of the whole by writing down ideas that developed from reading the transcript.
- ❖ One transcript was chosen and it was studied in order to identify the topics and themes.
- ❖ The researcher repeated the second step (above) with all the transcripts. The topics identified were clustered together and labelled according to their similarities.
- ❖ The topics were given codes according to similarities and these were placed in the transcripts next to the matching data segments.
- ❖ Topics that are related were grouped together.
- ❖ Topics were turned into categories. Categories in each transcript were identified. All the information in one category was collected together.
- ❖ The data material belonging to each category was put in one place and the analysis report could then be written based on the analysis.

1.6.6 Method of data verification

It is important to establish the trustworthiness of a study in order to validate the findings. Therefore, Guba's (cited in Krefting, 1991:214-222) model of ensuring the trustworthiness of qualitative data was applied. According to this model the following four aspects had to be addressed:

- **Truth value**

Truth-value has to do with the level of truth of the findings based on the research design, participants and the context (Krefting, 1991:215). The researcher had to ensure that the research findings were a true reflection of chemically dependent youths' perceptions, expectations, fears and support needs about being integrated into their family system after an in-patient rehabilitation programme of three months. The researcher established confidence in the truth of the findings through the use of the criteria given below

- ❖ **Interviewing techniques:** Being skilled in interviewing techniques, as a result of her social work training and practise experience assisted the researcher to do a more in-depth exploration bringing her closer to the perceptions, expectations, fears and needs

of chemically dependent youth in a rehabilitation centre about being reintegrated into their family systems.

- ❖ **Peer examination:** Guba (cited in Krefting, 1991:219) asserts that peer examination is a profitable criterion in data verification. The researcher is a member of the research committee at DFFRTC and also member of the research committee in the Department of Health and Social Development so she sought input and advice from her peers who are experienced in the field of qualitative research and more especially from the Head Office of the Department of Health and Social Development.
- ❖ **Authority of the researcher:** The researcher is working as a Social Worker at an in-patient rehabilitation centre called the Dr Fabian and Florence Ribeiro Centre. She has been working at the Centre since 2006 and working as a case manager for service users who have chemical dependency problems. She is currently conducting individual and group sessions with them on issues related to substance abuse and is also involved in outreach programmes to the community about substance abuse. The researcher also contributed to the compilation of an in-patient therapeutic structured programme for the Centre.
- ❖ **Triangulation of data sources:** According to Krefting (1991:219), triangulation is when data sources are assessed against one another to confirm data and interpretation in order to ensure that all aspects of a phenomenon have been investigated. In this study triangulation of data sources was employed by means of interviewing service users of different case managers, from different age groups, and both males and females. Furthermore, the Centre admits service users weekly, so these service users are all usually allocated to the same case manager and they go through the programme as one group for the three months, so in this study the researcher took service users from different groups and at different times of admission.

- **Applicability**

Guba (cited in Krefting, 1991:216) refers to applicability as the degree to which the findings can be applied to other contexts and settings or to other groups. Transferability is a method through which applicability can be established. The researcher provided a dense description of the research methodology employed to enhance the transferability of the research findings.

- **Consistency**

According to Guba (cited in Krefting, 1991:217) consistency refers to whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context. The researcher provided a dense description of the research methodology employed, peer examination and an independent coder to analyse the transcripts of the interviews independently as strategies to establish consistency.

- **Neutrality**

Neutrality refers to the extent to which the study findings are free from bias. Guba (cited in Krefting, 1991:216-217) states that neutrality in qualitative research should consider the neutrality of the data rather than that of the researcher and how transparent the researcher was during the whole research endeavour. The findings and recommendations were based strictly on the data obtained from the transcripts which thus prevented a subjective perspective from guiding the process. Triangulation of data sources assisted the researcher to achieve neutrality.

1.7 Ethical considerations

The concept “ethics” is defined “as a set of moral principles which is suggested by an individual or group, is subsequently widely accepted and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students” (Strydom in De Vos et al., 2005:57).

The following ethical issues were considered and attended to in conducting this research:

- **Informed consent**

According to Williams (as quoted by Strydom in De Vos et al., 2005:59), obtaining informed consent implies that all possible or at least adequate information on the goal of the investigation, the procedures which will be followed during investigation, the possible

advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the research, be explained to potential subjects or their legal representatives. In this research participants were provided with sufficient information about the study to allow them to decide to participate or not to participate. This was done verbally and in writing (see Addendum A and B). The participants were not coerced in any way. Informed consent forms were given to participants once they had been provided with all the information pertaining to the research and after they expressed their willingness to voluntarily participate in the research. All the participants in this study were 18 years and above and of sound mind so that guardian or parental consent was not necessary.

- **No harm to participants**

According to Babbie and Mouton (2001:522), social research should never injure the people being studied, regardless of whether they volunteer for the study or not. However, they might be harmed psychologically as they might be asked to reveal deviant behaviour, or attitudes they feel are unpopular. In this research arrangements were made to refer the participants to their therapists if needed after the interview.

- **Right to privacy and confidentiality**

According to Sieber (quoted by Strydom in De Vos et al., 2005:61), privacy pertains to aspects which are not normally for others to observe and analyse. In this research the participants' decision to share or not to share information was respected and the participants were informed that they could withdraw from the study at any time. Their anonymity was ensured through making use of pseudonyms, and not their real names. All study information that could reveal a participant's identity was stored in a safe place. This information was made accessible only to the researcher, the translator, as well as the independent coder and the study's supervisor.

- **Management of information**

According to Babbie and Mouton (2001:472), research should be concerned with the protection of participants' interests and wellbeing by protecting their identity. In this

research, management of information was done in accordance with the guidelines of Holloway and Wheeler (1998:45-46) which are as follows:

- Tapes, notes and transcripts of recordings must be locked away in a cabinet that only the researcher has access to in her office.
- Pseudonyms must be allocated to participants in order to hide their identities. Lists containing the real names and pseudonyms must not be stored near the tapes, notes or transcripts of the recordings but be stored in a private room in the researcher's home.
- The names of the participants must not be disclosed to the supervisors, promoters, typists or independent coder.
- Tape recordings and transcripts of the recordings must be destroyed after the research is complete.

1.8 Clarification of key concepts

Under this subheading the following key concepts central to this study will be defined:

The concept “family” as it will be applied in this study is defined as individuals who, either by contract or agreement, choose to live together intimately and function as a unit in a social and economic system. The family is the primary social unit which ideally provides care, trust, nurturing and socialization for its members. It seeks to provide them with physical, economic, emotional, social, cultural and spiritual security (Spies, 2000:33-36; National Youth Policy, n.d.).

Drug is defined as a substance that produces a psychoactive effect (National Department of Social Development, 2007:13).

Reintegration refers to “restore to a condition of integration or unity” (www.thefreedictionary.com). In the context of this study reintegration implied being reunified with the system the participant viewed as his or her “family”, whether by blood ties, or ties of association and adoption.

Youth The National Youth Policy defines a youth as a male or a female between the ages of 14 and 35 years (National Youth Policy. n.d.).

Substance is defined as an intoxicating, stimulating or narcotic chemical or drug (<http://oxforddictionaries.com>).

Substance Abuse can be defined as “a maladaptive pattern of excessive use of a substance, in which the person cannot reduce or cease intake despite physical harm or impaired social and occupational functioning” (Sue, Sue & Sue, 1994:317).

Relapse refers to “a violation of a set of rules about the frequency and pattern of use for a certain substance” (Stefanis & Hippus, 1995:86).

Treatment programmes can be described as “the clinical process by which the patients/clients are assisted in abstaining from their drug abuse/ dependency and in participating in rehabilitation to achieve their optimal level of functioning” (National Department of Social Development, 2007:15).

Chemical addiction “is a condition in which the use of a chemical substance causes social/emotional/spiritual and/or physical impairment. Indicators to be measured are tolerance, progression, withdrawal systems and loss of control” (Gossop, 1998:78).

Chemically dependent describes a condition when a person has formed a physical or psychological addiction or habituation to mood or mind altering chemicals such as alcohol or drugs (www.treatmentsolutionsnetwork.com/dictionary).

Rehabilitation is defined as a treatment or treatments designed to facilitate the process of recovery from illness, or disease to as normal a condition as possible (www.thefreedictionary.com).

Rehabilitation Centre is a facility providing therapy and training for rehabilitation (www.thefreedictionary.com).

1.9 A chapter-wise outline of the research report

The outline of the research report, chapter-wise, is as follows:

Chapter 1 provides an introduction and general orientation to the research report with specific focus on the following: introduction and problem formulation and rationale for the study, the research question, goal and objectives, research approach and design, ethical considerations, clarification of key concepts, and the content plan of the research report.

In Chapter 2 a description of how the researcher applied the qualitative research process for investigating the topic under discussion is provided.

In Chapter 3 the research findings are presented and subjected to a literature control.

In Chapter 4 the research report is summarised, with an outline of the overall conclusions and recommendations.

1.10 Dissemination of research results

The research findings are primarily presented in the form of this dissertation. The findings will also be disseminated in the form of a report to those who assisted with the research. An article will also be prepared and submitted for review and possible publication in a professional journal

1.11 Summary of the chapter

In this chapter the reader has been provided with a general introduction and orientation to this research report with specific focus on the following: introduction and problem formulation and rationale for the study, the research question, goal and objectives, research approach and design, ethical considerations, clarification of key concepts, and the content plan of the research report.

In the chapter to follow, the researcher will describe how the qualitative research approach introduced in Chapter 1 was applied in this study.

CHAPTER TWO

A DESCRIPTION OF THE QUALITATIVE RESEARCH PROCESS AND ITS APPLICATION

2.1 Introduction

Substance abuse among the youth in South Africa is increasing at an alarming rate. This was confirmed by President Nelson Mandela in his opening address to Parliament in 1994 when he singled out substance abuse as a growing problem facing South Africa and needing to be combated (Drug Advisory Board, 1999:1). Parliamentary reporter, Steenkamp, in a newspaper article in the *Rapport* of 11 May 2008, entitled: “Drank, dwelmsverswelg SA: Álmeer jong mense raak verslaaf: alkoholverbruik van die hoogste ter wêreld”, quotes Charles Perry, Director at the Medical Research Council focusing on research in drug and alcohol abuse. He stated that 12 years ago only two percent of the patients in rehabilitation centres for drug addicts were under 20 years of age. In 2008 this figure had risen to 20% and one out of every five patients in treatment for drug addiction was under 20 years of age (Steenkamp, 2008:13). Furthermore, the United Nations Office on Drugs and Crime in South Africa (United Nations Office on Drugs and Crime: Regional Office for Southern Africa, 2004:5) outlines several risk factors that are associated with substance abuse among the youth such as being young, male, possessing poor personal and social skills, as well as family factors including amongst others family disruption, ineffective supervision, criminality and parental drug use. The risk for the youth to get involved in chemical substance abuse is also common if the family does not take care of the youth emotionally or physically, or does not provide appropriate support and guidance. There is also a greater risk of becoming involved in the abuse of chemical substances if the young person is being abused mentally, physically or sexually. This being so, several characteristics of the parent-child relationship have been found to be related to substance use, including authoritative discipline, lack of monitoring, and poor communication. Communication problems, not only between parent and child, but often between parents as well, characterize the families of substance users. As a result of all these factors, school performance is often affected (United Nations Office on Drugs and Crime: Regional Office for Southern Africa, 2004:5 & 11).

According to the South African Community Epidemiology Network on Drug Use (SACENDU), an increasing number of young patients are being admitted to rehabilitation centres for drug-related problems. According to the report for May 2010, 46% of the patients admitted to treatment were younger than 25 years (South African Community Epidemiology Network on Drug Use, 2010(b):5). The South African Risk Survey conducted in 2004 indicates that nationally, 49% of teens use alcohol, 31% smoke and 13% use dagga regularly (A report on the 1st Biennial Substance Abuse Summit, 2007:5).

The treatment period for chemically addicted adolescents in rehabilitation centres should be long enough to be effective to produce positive change (Van der Westhuizen, 2007:5). It is during this time that the youth need all the support they can get from the family to deal with emotions associated with incarceration. Isaacson in Ashdown (2006:38) asserts that the basic emotions associated with the adolescent drug abuser in rehabilitation, although rarely expressed, are loneliness, shame, guilt, a need to belong and be accepted, anger and depression. If these feelings are not allowed expression in the family, the adolescent will most likely relapse after release and continue to abuse substances. Youth in rehabilitation centres often feel that they disappointed their parents or have stigmatised the family. This results (as indicated above) in feelings of shame and guilt. For a young person to be committed to a rehabilitation centre means that he/she is unable to break the cycle of cravings and therefore cannot quit by themselves, and to some this signifies defeat and helplessness. Through dedication, determination and a strong support network, youth who battle with alcohol and drug dependency can be completely healed and empowered to get on with their lives. This means with commitment to treatment, a young person can be successfully reintegrated back into the family of origin. However, it is normal for the young person to display fears and doubts about going home after being in a controlled environment which is drug free and problem free (Olszewski et al., 2009:8; Friedemann & Musgrove, 1994:no page number).

As seen from these introductory remarks it was against this background that the researcher decided to embark on this research project with the goal of developing an in-depth understanding of the perceptions, expectations, fears and needs of the youth after an in-patient treatment programme with a view to being reunified with their families.

In this chapter the researcher describe how she applied a qualitative research approach to assist her in seeking and acquiring a more grounded understanding of the perceptions, expectations, fears, and needs of participants who were addicted to chemical substances in relation to returning home to their family systems after being in an in-patient rehabilitation centre.

2.2 The nature of qualitative research

Customarily, researchers choose to approach such research from one of two camps: either qualitative or quantitative, and these paradigms can even be used in combination (Hollis Martin & Fleming, 2010:794). According to Fouché and Delport (in De Vos et al., 2005:74-75) the qualitative research approach refers to research that “elicits participants’ accounts of meaning, experience or perception” whereas a quantitative research approach seeks to test or measure the predictive cause and effect relationship existing between variables in the social world. According to Stake (2010:11), quantitative research relies heavily on linear attributes, measurements and statistical analysis while qualitative research complements quantitative research in humanising the theories and experiments by investigating and reporting the personal experiences, perceptions and understanding of research participants related to social phenomena. Nicholls (2009: 590) adds that qualitative research is aimed at theory development by following a process of inductive reasoning, while quantitative research is more inductive in nature and aimed at testing a theory.

As stated in the previous chapter, the researcher decided to approach this research project from a qualitative point of view.

According to Hennink, Hutter and Bailey (2011:8), the qualitative research approach, through the utilisation of research methods such as in-depth interviews, focus group discussions and observations, allows the researcher to examine people’s experiences in detail from the perspectives of those people. The qualitative researcher tries to come to understand the meanings and interpretations the people under study give to behaviour, events, experiences and objects.

In addition to the characteristics of qualitative research mentioned in Chapter 1: Section 2.3.1, the following characteristics of qualitative research are provided:

- ❖ Qualitative research follows a person-centred approach, it is empathetic as it aims to try and understand individual perceptions. The qualitative research approach is personalistic as it seeks people's point of view or frame of reference and often issues are emic (emerging from the people) which is referred to as the "emic perspective" (Stake, 2010:15).
- ❖ It is more concerned in seeking uniqueness than commonality (Stake, 2010:15).
- ❖ In qualitative research, the relationship between the researcher and the participants is a natural one that evolves as the study progresses and the researcher seeks to explore the feelings, meanings and the personal context of the participants' lived experiences and reflects on the meaning they attach to the latter (Nicholls, 2009:590).
- ❖ Qualitative interviewing (i.e. in-depth interviews) is one of the richest approaches to data collection as it invites participants and affords them opportunities to tell their stories as they were experienced and also enables the researcher to gain an understanding of the richness of a personal event and the factors surrounding it (Jack, 2010:5).
- ❖ In qualitative research the researcher is often the main research instrument (Stake, 2010:15).

Based on the above mentioned explanations of what qualitative research is and the characteristics inherent in this approach the researcher came to the realisation that this approach was well-suited to enable her to gain first-hand information from the participants on their perceptions, expectations, fears, and needs relating to the event of returning home to their family systems after being in an in-patient rehabilitation centre.

2.3 Research design

Nieuwenhuis (in Maree, 2007:70) explains that the research design is the plan or strategy that the researcher uses to implement his or her study. He further explains that this plan is based on the researcher's approach to research. According to the researcher's understanding of research design, it is how one intends conducting the research project concerned.

In this research project the researcher used an **explorative, descriptive and contextual research designs**. By way of revision the researcher will define each of the concepts and continue by explaining how the strategy of inquiry was applied in the context of this research.

An explorative research design is employed when a researcher examines a new interest or when the subject of study itself is relatively new (Babbie and Mouton, 2001:79). Brink (2006:202) further mentions that explorative research is conducted when little is known about the phenomenon that is being studied. In view of the fact that the perceptions, expectations, fears and support needs of chemically dependent youth at an in-patient rehabilitation centre about their reintegration into their family system seems to be sparsely documented in the literature, the researcher employed an explorative design in order to gain an in-depth understanding of the perceptions, expectations, fears and support needs of chemically dependent youth in relation to being reintegrated with their families following a three-month treatment programme at an in-patient rehabilitation centre.

A descriptive research design is employed when a researcher wants to observe and then describe what was observed. A descriptive research design is a scientific method which involves observing and describing the behaviour of a subject without influencing it in any way (Engel & Schutt, 2010:379). Subsequent to exploring the perceptions, expectations, fears, and needs about reintegration into the family system of chemically dependent youth at a rehabilitation centre, the data were analysed and then the researcher employed the descriptive research design to describe the perceptions, expectations, fears, and support needs of chemically dependent youth about reintegration into the family system following their in-patient treatment.

The contextual research design seeks to gather evidence of a participant's perceptions according to the large context in which they occurred (Kayrooz & Trevitt, 2005:10). According to Babbie and Mouton (2001:272), the concept "contextual" relates to the understanding of events against a specific background or in a specific context and how such a context gives meaning to the events concerned. In this research, the researcher's intentions were to explore and describe the chemically dependent youths' perceptions, fears and support needs from the context of being reintegrated back into their family systems and for this reason the contextual research design was included as part of the strategy of inquiry.

2.4 The research method

The concept “research method” refers to forms of data collection, analysis and interpretation that researchers employ in a study (Creswell, 2009:15). Included within this concept are also the aspects of population, sampling and sampling techniques. These aspects will be presented in the discussion as they were utilised.

2.4.1 Population, sampling and sampling techniques

In recapping, the concept “**population**” was described in Chapter 1: Section 2.4.1 as the entire group of persons or objects of interest to the researcher or in other words that met the criteria the researcher was interested in (Brink, 2006:123). Jupp (2006:265) concurs and notes that the concept “**population**” refers to the group of people or the unit of analysis which is the focus of the study. The population is the entire collection of entities the researcher seeks to understand or, more formally, about which one seek to draw an inference (Litt, 2010:1053).

The population of this study comprised any youth service users (ages 18 – 35 years old) at the Dr Fabian and Florence Ribeiro Treatment Centre who were left with two weeks to complete of their three-month in-patient treatment programme and who were returning to their families. As it was impossible to include the whole population in the study due to time and money constraints the researcher had to draw a sample from the population. With reference to qualitative sampling, Geertz, Holloway and Wheeler (in Nicholls, 2009: 590) postulate that qualitative studies are based on quality rather than quantity, with the researchers searching for a sample for participants, and with the sample being a subset of persons/elements drawn from the population (cf. Shapiro, 2008:776), who might offer rich, ‘thick’ descriptions of the phenomena under study. Donalek and Soldwisch (2004:356) concur and point to the fact that qualitative researchers purposively or intentionally seek out participants for inclusion in the sample because of their knowledge of and ability to describe the phenomenon or part of the phenomenon under study. In view of this, a qualitative researcher tends to choose participants purposively through the use of purposive sampling. This sampling is used when the researcher chooses a sample on the basis of knowledge of the population, its elements and the nature of the research aim (Babbie & Mouton, 2001:166). This sampling technique was used

to obtain a sample of youth from the population described above and who met the criteria for inclusion stipulated in Chapter 1: Section 2.4.1.

A specific sample size was not determined at the outset of the study, but after 12 participants were interviewed and the interviews transcribed and read through by both the researcher and study's supervisor it was concluded that a point of "data "saturation" had been reached (i.e. that is when the information being gathered becomes repetitive (De Vos et al., 2007:294; Brink, 2006:136) and the process of sampling more participants was subsequently terminated.

2.4.2 Recruitment of participants and how they were prepared

The researcher started by writing a letter to the Department of Health and Social Development to ask permission to do research (see Addendum D). After the permission was granted by the Department of Health and Social Development (see Addendum E), the researcher then sought permission from the management of the Dr Fabian and Florence Ribeiro Treatment Centre with a letter showing permission had been granted by the Department of Health and Social Development. The Centre's permission was granted (see Addendum E) and then the researcher contacted the case managers (Social Workers) to get more information (i.e. a list of names of the potential participants who met the inclusion criteria for possible inclusion in the study). The researcher then contacted the case managers who acted as **gatekeepers**. Engel and Schutt (2009:320) define a **gatekeeper** as a person who grants researchers access to the setting; in this research the case managers assisted by identifying, establishing contact and setting up appointments with the service users who met the inclusion criteria (see Chapter 1: Section 2.4.1 for the latter). During the face-to-face contact with the potential participants the researcher introduced herself to them, she then explained the purpose and the criteria for inclusion and what their participation in this study entailed was also pointed out to them. They were informed that their participation in the study was voluntary and that they had the right to refuse to participate in the study. It was pointed out to them that their refusal to participate would not affect their treatment programme at the Centre in any way and they would not be discriminated against on the grounds of refusal to participate. The potential participants were also informed that the contents of the data collected would be discussed with the researcher's supervisor and that the contents of the report might be published in a journal as an article. Participants were also informed that they would remain anonymous and that the researcher would use pseudonyms so that they cannot be linked to the contents of the data collected and documented.

Furthermore, the researcher went through the questions that were going to be asked during the interview. She mentioned that the interview was going to be digitally recorded and also sought their permission in this regard, should they consent to participate. After sharing all the information verbally she proceeded by giving each of the potential participants a letter detailing all the information mentioned thus far, as well as an informed consent form (see Addendum A and B) for them to read at their bungalows (in their rooms) and also to be given time to make a decision on whether or not to participate in the study. A follow-up appointment was then made for the potential participants to give an answer to whether they agreed or disagreed to participate and for the interview to be conducted. During this contact and based on the participant's decision to participate then the researcher once again went through the letter requesting their participation and the consent form which afforded the potential participants an opportunity to ask questions. Upon completion of this she then requested them to sign the consent form as proof that they had been comprehensively informed about the study and based on the information provided consented to participate voluntarily in the study. She then proceeded to collect the data through the use of face-to-face semi-structured interviews.

2.4.3 Method of data collection

As mentioned in the previous paragraph, face-to-face semi-structured interviews were employed in this research to collect the data. An interview is defined as a method of data collection where the interviewer obtains data from participants in a face-to-face encounter (Brink, 2006:151). **Semi-structured interviews** are used by the researcher to obtain a detailed picture of the participants' experiences and beliefs about or perceptions or accounts of a particular topic (Greef in De Vos et al., 2005:296). This method gives the researcher and the participants the opportunity to be flexible. According to Mack et al. (2005: 29), during in-depth interviews, the person being interviewed is considered "the expert" and the interviewer is considered "the student". The researcher has the intention and the desire to learn everything the participant can share about the research topic. During in-depth interviews the researcher engages with participants by posing questions in a neutral manner, listening attentively to participants' responses, and asking follow-up questions and probes based on those responses. The researcher deliberately refrains from leading the participant according to any preconceived notions, nor are participants encouraged to provide particular answers by expressing approval or disapproval of what they say (Mack et al., 2005:29).

In order to explore the perceptions, expectations, fears and support needs of chemically dependent youth in relation to being reintegrated with their families following a three-month treatment programme at an in-patient rehabilitation centre the researcher posed the questions related to the topic under investigation (contained in an interview-guide) in a flexible order to the participants during the interviews. (For a list of these questions, as well as the questions posed to the participants to enable the researcher to compile a biographical profile of the participants the reader is advised to consult Chapter 1: Section 2.4.2.) Based on the fact that all the participants were comfortable to express themselves in English, all the interviews were conducted in English. All the participants agreed to the interviews being digitally recorded. In view of the fact that the researcher was therapeutically involved with two participants previously, she made it clear to these participants, as well as all the others that the interviews to be conducted would not be of a therapeutic nature what so ever, but was purely for research purposes. The researcher also made notes, especially of the non-verbal behaviour observed during the interviews. All the interviews were conducted in an office at the Dr Fabian and Florence Ribeiro Centre and they lasted approximately one hour.

During the interviews with the participants the researcher used various interviewing techniques to enhance the flow of the communication between the participants and herself and to get more information from the participants. The following interviewing techniques were used extensively:

- ❖ **Probing:** According to Bernard and Ryan (2010: 31-32), probing is a key to successful interviewing and it has different types namely:
 - **The silent probe** which involves nothing more than waiting for the participants to continue their thoughts. After posing a question the researcher remain silent for a few seconds in order to allow the participants to formulate and share a response.
 - **The echo probe** involves repeating the last thing the participant has said and asking them to continue “You said it is so bad, what do you mean is so bad”
 - **The “uh-huh” probe** involves encouraging the participant to continue with narratives by just making affirmative comments like “uh-huh,” “I see, Yes” and so on
 - **The “tell me more probe”** involves direct probing for more information from the participant, for example. “Could you tell me more about that”

- **The long question probe** involves asking long questions to get more information; for example in this research the researcher asked the following to one of the participants: “How can your family assist you in relation with your integration back into the family system?”

- ❖ **Attentive listening** was also employed as an interviewing technique in that the researcher attended verbally and non-verbally to the participants in order to let the participants experience that she was physically, emotionally and intellectually present and to create a warm, accommodating and trusting environment (Du Toit et al., 2003:128 & 141). This technique enabled the researcher to also hear the verbal and non-verbal messages that the participants were trying to convey; this helped in building trust with participants and encouraged them to share more information about their perceptions, expectations, fears and support needs about going back to their families after rehabilitation.

- ❖ **Empathy** was modelled. Empathy is defined “as the ability to put aside one’s own frame of reference and attempts without preconceived ideas and be able to hear and understand the client and convey such understanding to the client verbally and non-verbally” (Du Toit et al., 2003:152). This technique was used to build trust and for the participants to realise that the researcher was with them, prepared to listen to them in a non-judgmental manner while they were sharing their perceptions, expectations, fears and needs in relation to being reintegrated with their families following a three- month treatment programme at an in-patient rehabilitation centre.

- ❖ **Clarification** as an interviewing skill was employed and is defined as “a way of finding a meaning to what a client is thinking or feeling aiming for a deeper level of truth or accuracy” (Maree, 2007:5). This technique was used in this research to ensure that what participants were saying was not misinterpreted. The researcher informed the participants when she was unsure or confused about what they had communicated and requested them to clarify the matter.

- ❖ **Paraphrasing** was also employed as an interviewing technique. In employing this interviewing technique the researcher repeated what the participants said but using different words (Maree, 2007:5). This technique was used to alert the participants to what they were saying and to ascertain that the researcher had understood and interpreted what they said correctly.

2.4.4 Pilot Study

A pilot study is defined as a small initial study designed to test the quality of the data collection procedure and to gather information prior to a larger study, in order to improve the latter's quality and efficiency (Engel & Schutt, 2010:387). The pilot study was conducted in order to ensure that the participants were able to answer the research questions and also to identify possible difficulties with questions (Leedy & Ormrod, 2005:152). A pilot study was conducted with two participants. The value of this exercise was that it provided the researcher with an opportunity to practise her interviewing skills. She also concluded that the questions included in the interview-guide were pitched at the participants' level of comprehension as they responded with ease to the questions. These pilot interviews were also digitally recorded and were included in the data set to be analysed.

2.5 Data analysis

Based on Tutty, Rothery and Grinnell's (1996:90) and Tesch's (cited in Creswell, 1994:154) viewpoints, qualitative data analysis involves the 'taking apart' or 'de-contextualising', sifting, and sorting of the masses of information acquired during the process of data collection, and organizing or 're-contextualizing' it in such a way that the themes and categories and interpretations that emerge from this process of data analysis address the research problem and the ensuing question(s) posed at the outset of the research. Bernard and Ryan (2010:109) further state that data analysis is a search for patterns in the data collected and for ideas that help explain why those patterns are there in the first place. In qualitative studies data analysis starts before the process of data collection commences in that the researcher needs to have some idea of what type of data is required and what will be the best way to analyse the data. The process of data analysis continues concurrently with the process of data collection in that the data are transcribed and analysed soon after being collected in an effort to alert the researchers to aspects not properly probed in a previous interview and then to plan a concerted effort to probe these aspects should they surface in consecutive interviews (Engel & Schutt, 2010:242).

In this study the researcher followed a pattern whereby she, after conducting an interview, transcribed it word-for-word and forwarded it via e-mail to the study's supervisor for scrutiny and feedback. The researcher also read through each transcript and made some notes of the

ideas that came to mind and interviewing techniques that needed to be employed more in follow-up interviews and also aspects not probed enough in previous interviews to be probed specifically should they surface in future interviews. This way of working paid off in that it assisted both the researcher and the study's supervisor to confidently take the decision after 12 interviews had been conducted, transcribed and scrutinised, that data saturation had been achieved and that the process of sampling and interviewing the sampled participants could be discontinued. The researcher then employed the services of an independent coder to analyse the data independently from her and afterwards they engaged in a consensus discussion facilitated by the study's supervisor to consolidate the themes and categories that emerged from the processes of data analysis.

Both the researcher and the independent coder used the steps for qualitative data analysis as proposed by Tesch (cited in Creswell, 2009:186) to assist them in analysing the data. In the discussion to follow the researcher provides an account of how she applied these steps:

- ❖ The researcher attentively read through all the transcriptions of the interviews conducted and wrote down any ideas that came to her mind.
- ❖ She then picked up the transcript on the top of the pile, went through it and engaged in an exercise to uncover the underlying meanings contained in it and wrote her thoughts in this regard down in the margins of the transcript.
- ❖ She followed the step above in respect of all the transcripts and upon completion she made a list of all the topics that had transpired. Similar topics were clustered together.
- ❖ The researcher then took the list of topics and searched for a unique identifiable abbreviation for each of the topics and wrote it down next to each topic. With this list in hand she went back to the data and she wrote the abbreviation for a specific topic next to a segment of data corresponding to a particular topic
- ❖ The researcher next found the most descriptive wording for her topics and turned them into themes. She looked for ways of reducing her total list of categories by grouping topics that relate to each other. The researcher made a final decision on the abbreviation for each theme and organised them alphabetically
- ❖ By using the cut-and-paste method the researcher assembled the data material belonging to each theme in one place and performed a preliminary analysis.
- ❖ Where she considered it necessary she recoded some sections of the data and on completion she commenced with reporting the research findings to be found in the next chapter of this research report.

2.6 Data verification

In this study trustworthiness was addressed through Guba's model (cited in Shenton, 2004: 64-73) as a way of validating the findings. According to this model the following four aspects were addressed:

- **Credibility**

Credibility relates to truth-value and according to Shenton (2004:64) credibility is concerned with how congruent are the findings of a researcher with reality. The researcher ensured that the research findings were a true reflection of the perceptions, expectations, fears and needs of chemically dependent youth in relation to being reintegrated with their families following a three-month treatment programme at an in-patient rehabilitation centre through the employment of the following strategies.

- ❖ **The utilisation of various interviewing techniques and skills** such as probing, empathy and listening enabled the researcher to do a more in-depth exploration of the topic under investigation (Shenton, 2004:64).
- ❖ **The development of an early familiarity with the culture of participating organisations:** According to Shenton (2004:65), this involves a prolonged engagement between the researcher and the participants in order for the researcher to gain an adequate understanding of an organisation and to establish a relationship of trust between the researcher and the participants. In this research the researcher had been employed at the Dr Fabian and Florence Ribeiro Treatment Centre since 2006 and she had provided counselling to the youth who are chemically dependent and all the service users who were admitted in the centre knew her, so that the researcher knew a lot about the centre and had developed a relationship of trust with the youth who are chemically dependent.
- ❖ **Background, qualifications and experience of the researcher:** The researcher is still working as a Social Worker at the in-patient rehabilitation centre called the Dr Fabian and Florence Ribeiro Centre. She has been working at the Centre since 2006 and is a case manager for service users who have chemical dependency problems. She is currently conducting individual and group sessions with them on issues related to substance abuse and is also involved in outreach programmes to the community

about substance abuse. The researcher also contributed to compiling an in-patient therapeutic structured programme for the Centre.

- ❖ **Triangulation:** According to Shenton (2004:66) triangulation involves the use of a wide range of research participants and occurs when an individual's viewpoints and experiences can be verified against others. In this research triangulation of data sources was used by interviewing different service users from different case managers, who differed in age while both males and females were interviewed. Furthermore the Centre admits service users weekly, and these service users are all allocated to the same case manager and they go through the programme as one group for a period of three months, so in this study the researcher deliberately took service users from different groups, different case managers and different times of admission.
- ❖ **Tactics to help ensure honesty in informants:** this entails allowing participants the opportunity to voluntarily participate in the research in order to ensure honesty. In this research the participants were not coerced to participate but were given the opportunity to participate voluntarily and were also informed of the right to withdraw from the study at any point and that withdrawing would not affect their treatment at the Centre in any way. Furthermore, an informed consent form was also given and read to the participant prior to accepting to participate in the study (Shenton, 2004:66).
- ❖ **Frequent debriefing sessions between the researcher and her supervisor:** in this study the researcher transcribed the interviews and submitted each and every interview transcript to the supervisor to be checked and commented on, then used the inputs from the supervisor to improve on the next interview (Shenton, 2004:67).
- **Transferability** relates to applicability (Krefting, 1991:216). According to Shenton (2004:69-70) transferability has to do with the ability to be able to demonstrate that the results of the research at hand can be applied or generalised to a wider population. This can be achieved by providing a sufficiently thick description of the phenomenon under investigation and the methodology employed to investigate the phenomenon under study. The researcher attempted to ensure transferability by providing a dense description of the research methodology employed and the research findings which emerged from this endeavour (See Chapters 2 and 3 in this report).

- **Dependability** relates to consistency (Krefting, 1991:216) and, according to Shenton (2004:71-72), dependability refers to whether the findings would be consistent if the research were repeated with the same participants, with the same method and in a similar context. Dependability can be achieved by reporting the research methodology processes followed comprehensively so that a dependability audit will be possible. The researcher made use of dense description of the research method and an independent coder to analyse the transcripts of the interviews independently to establish dependability.
- **Confirmability** relates to neutrality or transparency (Krefting, 1991:217) and employs strategies to ensure that the study's findings are free from bias (i.e. that the research findings are the result of the experiences and ideas of the participants, rather than the characteristics and preferences of the researcher). The findings and recommendations need to be based on the data obtained from the transcripts in order to prevent the researcher's subjective perspective from guiding the process. Triangulation of data sources mentioned above was employed by the researcher to achieve confirmability (Shenton, 2004:72).

2.7 Ethical considerations

In the context of research "ethics" prescribe to researchers the obligation to protect their participants against deception, dangerous procedures and invasion of privacy (Graziano & Raulin, 2010:60). Participants have a right to know what the study is about and researchers must give enough knowledge about the research in order for the participants to make an informed choice whether to participate or not in the study.

The following ethical issues were applied in conducting this research:

- **Voluntary Participation**

According to Babbie and Mouton (2001: 521), social research often represents an intrusion into people's lives, often requires people to reveal personal information about themselves which might be unknown to significant others and/or to other people, or information that is sensitive and this information might need to be revealed to strangers, so this requires participants to voluntarily participate in the study. In this study the researcher pointed out to

participants that their participation in the study was voluntary and that they had the right to refuse to participate in the study. It was pointed out to them that their refusal to participate would not affect their treatment programme at the Centre in any way and they would not be discriminated against on the ground of refusal to participate.

- **Informed consent**

According to Brink (2006:35), in order to obtain informed consent the researcher must provide the participant with comprehensive and clear information regarding the participant's participation in the study. This information should include the following: (1) the type of information needed from the participants, (2) the degree of understanding that the participant must have in order to give consent, and (3) the fact that giving consent is voluntary.

In order to obtain the participants' informed consent she executed the following activities: Upon permission being granted from the relevant authorities (i.e. Department of Health and Social Development and the Management of the Dr Fabian and Florence Ribeiro Treatment Centre) to conduct the research she contacted the case managers (Social Workers) who acted as **gatekeepers**. Engel and Schutt (2009:320) define a **gatekeeper** as a person who grants researchers access to the setting. In this research, the case managers (as gatekeepers) assisted by providing information (i.e. a list of names of the potential participants who met the inclusion criteria) for possible inclusion in the study (see Chapter 1: Section 2.4.1). The researcher then, through the case managers, established contact and set up appointments with the service users who met the inclusion criteria (see Chapter 1: Section 2.4.1). During the face-to-face contact with the potential participants the researcher introduced herself to them, she then explained the purpose and the criteria for inclusion and it was also pointed out to them what their participation in this study entailed. They were informed that their participation in the study was voluntary and that they had the right to refuse to participate in the study. It was pointed out to them that their refusal to participate would not affect their treatment programme at the Centre in any way and they would not be discriminated against on the ground of refusal to participate. The potential participants were also informed that the contents of the data collected would be discussed with the researcher's supervisor and that the contents of the report might be published in a journal as an article. Participants were also informed that they would remain anonymous and that the researcher would use pseudonyms so that they cannot be linked to the contents of the data collected and documented. Furthermore, the researcher went through the questions that were going to be asked during

the interview. She mentioned that the interview was going to be digitally recorded and also sought their permission in this regard, should they consent to participate. After sharing all the information verbally she proceeded by giving each of the potential participants a letter detailing all the information mentioned thus far as well as an informed consent form (see Addendum E) for them to read in their bungalows (rooms) and also to be given time to make a decision whether or not to participate in the study. A follow-up appointment was then made for the potential participants to give an answer to whether they agreed or disagreed to participate and for the interview to be conducted. During this contact and based on the participant's decision to participate the researcher then once again went through the letter requesting their participation and the consent form and afforded the potential participants an opportunity to ask questions. Upon completion of this she then requested them to sign the consent form as proof that they had been comprehensively informed about the study and based on the information provided consented to participate voluntarily in the study.

- **No harm to participants**

According to Babbie and Mouton (2001:521), social research should never injure the people being studied, regardless of whether they volunteer for the study or not. However, they might be harmed psychologically as they might be asked to reveal deviant behaviour or attitudes they feel are unpopular. In this research there was one participant who was emotional during the interview and after the interview the researcher asked permission from the participant to refer her for counselling to her Social Worker at the Dr Fabian and Florence Ribeiro Treatment Centre and she agreed to be referred, and then she was indeed referred to the Social Worker to provide counselling. In this research no participant was forced or threatened to participate in the research. The research was conducted at the rehabilitation centre and in an environment that the participants were familiar with and where they felt safe.

- **Right to privacy and confidentiality**

According to Sieber (quoted by Strydom in De Vos et al., 2005:61), privacy is described as relating to aspects which are not normally for others to observe and analyse. In this research the participants' decision to share or not to share information was respected and participants were informed that they could withdraw from the study at any time. Their anonymity was ensured through making use of pseudonyms. All study information that could reveal a participant's identity was stored in a safe place. This information was accessible only to the

researcher, the independent coder and the researcher's supervisor. The researcher made sure that participants' identities were withheld because the researcher used pseudonyms. Pseudonyms were given and only the researcher knew which participant was linked to which pseudonym.

- **Management of information**

According to Babbie and Mouton (2001:472), research should be concerned with the protection of participants' interests and wellbeing by protecting their identity. In this research the researcher followed the pointers for management of information in qualitative studies proposed by Holloway and Wheeler (1998:45-46) in that:

- ❖ She safely locked away all the audio recordings of the interviews, field notes and transcripts of recordings in a cabinet in her office to which only she had access.
- ❖ Pseudonyms were allocated to participants in order to hide their identities. The lists containing the real names and pseudonyms were not stored near the audio-recording or the transcripts of the recordings but were stored in a private room in the researcher's home.
- ❖ The names of the participants were not disclosed to the supervisor and the independent coder.
- ❖ She promised the participants that the audio-recordings and transcripts of the recordings would be destroyed after the research was complete.

2.8. Conclusion

The researcher chose the qualitative research format as the suitable research approach to answer the research question. This method made it possible for the researcher to explore and describe what are the perceptions, expectations, fears, and needs of participants who were addicted to chemical substances in relation to returning home to their family systems after being in an in-patient rehabilitation centre. Purposive sampling was employed in this study as it enabled the researcher to obtain a sample of youth from the population of this study which consisted of any youth service users (ages 18 – 35 years old) at the Dr Fabian and Florence Ribeiro Treatment Centre who were left with two weeks to complete their in-patient treatment programme and who were returning to their families; also this sampling technique was chosen as the chemically dependent youth were regarded as “experts” in answering the research question and therefore were purposefully chosen for the study. Semi-structured

interviews were used as a form of data collection. The interviews were tape-recorded, then transcribed. In analyzing data Tesch's (cited in Creswell, 2009:186) steps for qualitative data analysis were used to assist in analysing the data. Trustworthiness was addressed through Guba's model (cited in Shenton, 2004: 64-73) to validate the findings. Ethical considerations focused on voluntary participation, informed consent, no harm to participants, and the right to privacy and confidentiality of participants and were attended to fully during the research study.

CHAPTER 3

RESEARCH FINDINGS

3.1 Introduction

This research aimed to explore and describe the perceptions, expectations, fears and support needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system. The literature consulted clearly points to the fact that drug use and abuse contributes to the destruction of individuals, families and communities and has serious consequences for the health and well-being of the abuser and negatively impacts all the spheres of this person's life (i.e. education, health, employment, peer, social and family relationships (Jackson, Usher & O'Brian, 2007:322; Dube, 2007:28; Schäfer, 2011:35). In concurring with the aforementioned, Collins, Ready, Griffin, Walker and Mascaro, (2007:430) postulate that chemical substance abuse during adolescence is connected with an increased exposure to disease, susceptibility to poverty, an increased risk of becoming involved in crime and violence and seriously threatens the realisation of educational and career goals. Looking at the phenomenon of substance abuse from a systemic perspective it becomes clear that when one subsystem (i.e. a youth) abuses chemical substances it has an effect on the whole system. Jackson et al. (2007:322) confirm the former train of thought and further state that research findings reveal that families become fractured and split as a result of the on-going destructive and damaging behaviour of the drug-abusing adolescent family member. The drug abuse of the adolescent family member has a profound effect on family functioning, touches every other member of the immediate family, and stains every aspect of family life. The former is due to the fact that a person's serious drinking or drug problems are, by their very nature, associated with a number of characteristics which are damaging to intimate relationships and can be extremely unpleasant to live with (Orford, Velleman, Copello, Templeton & Ibanga, 2010:38-39).

Variables within the family such as: family and marital conflict, parental chemical substance abuse, parental criminality, the lack of parental supervision, erratic and hard discipline and weak emotional attachments to parents have been consistently mentioned as predictors in relation to anti-social behaviour, and amongst others the chemical substance abuse of adolescents and the youth (Haines & Case, 2005:169).

While the literature referred to above points to factors, behaviours and manifestations in the family system that can render subsystems within this system vulnerable to drug abuse, other literature points to the fact that the consistent and regular communication of parental warmth and affection to the child, support of the child's competencies, modelling of clear pro-social expectations from the parents towards the child, monitoring of child, and consistent and moderate discipline, are good characteristics in inhibiting young people from engaging in substance abuse and hence improve family relationships (Velleman, Templeton & Copello, 2005:96; Park, Kim & Kim, 2009:57; Collins et al., 2007:431).

In embarking on a journey to ascertain the amount of literature available on the topic under investigation the researcher came to the conclusion that there was a scarcity in the literature within the field of social work specifically articulating the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system. In view of this, the researcher decided to undertake this research project with the aim of coming to understand the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system. She afforded the participants an opportunity to share information in this regard by giving them a voice to tell their story (Jack, 2010:4).

In Chapter 2 of this research report the researcher provided a description of the research methodology employed to investigate the topic under discussion. This research endeavour was approached from a qualitative perspective. According to Hennink et al. (2011:8), the qualitative research approach, through the utilisation of research methods such as in-depth interviews, focus group discussions and observations, allows the researcher to examine people's experiences in detail from the perspectives of these people themselves. In this research the perceptions, expectations, fears and support needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system were explored.

The sample of this study was taken from the population of all youth service users (ages 18 – 35 years old) at the Dr Fabian and Florence Ribeiro Treatment Centre² who were left with

² Hereafter referred to as DFFRTC

two weeks to complete their in-patient treatment programme and who were returning to their families. The demographic information of the sample is discussed below in section 3.2.

Data collection was done by means of semi-structured interviews and all the interviews were digitally recorded. During the interviews with the participants the researcher used various interviewing techniques such as probing, empathy, attentive listening, clarification and paraphrasing to enhance the flow of the communication between the participants and herself and to get more information from the participants.

Data were analysed according to the steps for qualitative data analysis as proposed by Tesch (cited in Creswell, 2009:186) (see Section 2.4.3 and 2.5). Data verification was (amongst other features) addressed through the use of an independent coder.

In this chapter the research findings that emerged as result of the processes of data analysis and the consensus discussions between the researcher, the independent coder and the study's supervisor will be presented.

Before presenting the themes and sub-themes that emerged from the aforementioned processes the demographic data pertaining to the participants will be presented in the next section.

3.2 Demographic Data

The demographic details of the 12 participants who participated in this study are displayed in Table 3.1 on the following page:

TABLE 3.1: BIOGRAPHICAL INFORMATION OF PARTICIPANTS

	AGE	GENDER	DRUG OF CHOICE	RACE	RESIDENCE	EDUCATION & EMPLOYMENT	PREVIOUS REHABILITATION CENTRES	PREVIOUS ADMITTANCE TO REHAB
A	25	Female	Cocaine, Methcathinone, ecstasy	White	Unknown	Unknown		0
B	27	Male	Cocaine, Methcathinone, ecstasy, Mandrax	Coloured	Eersterust, Pretoria, Gauteng	Unknown	Castle Carey Vista	2
C	20	Male	Nyaope, rocks, crystal methamphetamine	Black	Unknown	Unemployed. Finished Grade 12, plus did Introduction to Law (incomplete)	Castle Carey Vista Stabilis	3
D	24	Male	Heroin and rocks	Black	Mamelodi, Gauteng	Fire-fighter at City of Tshwane. No qualification mentioned.	Stabilis	1
E	25	Male	Dagga and alcohol	Coloured	Ennerdale, Gauteng	Boiler maker, but unemployed. Prospect of	Church farm	1

						work when he left DFFRTC.		
F	20	Female	Mandrax, glue, dagga, rocks and crystal methamphetamine	Coloured	Kimberley, Northern Cape	Unemployed. No qualification mentioned.		0
G	28	Male	Dagga and heroin	Black	Soshanguve, Gauteng	Unemployed. Finished Grade 12.	Outpatient Centre	1
H	19	Female	Nyaope ³	Black	Midrand, Gauteng	Never worked.		0
I	22	Male	Mandrax, cocaine, dagga and alcohol	Coloured	Unknown	Grade 8. Dropped out of school. Never worked.	DFFRTC	1
J	31	Female	Heroin and dormical	White	Kempton Park, Gauteng	Chartered Accountant.		0
K	29	Male	Cocaine	Black	East Rand	Boiler maker, but unemployed.		0
L	21	Male	Heroin, Ecstasy, Rocks and Methcathinone	Black	Ekangala	Unemployed.	Moreleta Private Institution	1

³Nyaope is a mixture of heroin and dagga (Hosken, Pretoria News. 11 November 2009:3).

Complementing the information contained in Table 3.1 above, a discussion of the demographic information about the participants will be provided in the section to follow.

3.2.1 Age distribution of the participants

The ages of participants ranged from 19 to 31 years of age. Ten participants were between 20 and 30 years of age, with the other two at 19 and 31 respectively.

One inclusion criterion of this study was youth service users who were between the ages 18-35 years, which explains the ages of participants. According to South African Community Epidemiology Network on Drug Use (2011:3), the average age of persons across treatment sites in South Africa for treating patients with chemical substance dependence seen by these treatment centres during January to June 2010 was 28-34 years which to a certain extent corresponds with the ages of participants in this study.

3.3.2 Gender distribution

One inclusion criterion for participants in this study was to include both males and females in order to gain a broader understanding of the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system and therefore both genders were used. However, from Table 3.1 above, it became clear that the researcher interviewed more males than females (i.e. four female participants and eight male participants). The reason for this is as a norm DFFRTC has fewer females who are admitted to the centre (this was confirmed by the Assistant Social Work Manager of the DFFRTC, Mr Gordon Cairns). South African Community Epidemiology Network on Drug Use (2010:16) concurs by indicating that male patients continue to dominate admissions for treatment. South African National Council on Alcoholism and Drug Dependence's National Treatment Report (2008-2009:3) indicates similarly that despite a 26% increase in clients during the past year, the gender ratio has remained almost the same as in the past three years. The majority of clients, namely 9065 (82%) were males with 972 females (18%) in their in-patient and outpatient treatment centres in all the provinces in South Africa.

3.2.3 Race distribution of the participants

Six of the participants were black, four coloured and two whites, no Indians participated in the study. The race distribution reflects the demographic profile of the youth in South Africa. This is confirmed by Golda & Makiwane (2009:10) who note that blacks have an overwhelming majority share of the national youth population (83.7%). The shares of other population groups are 7.9%, 2.2%, 6.2% for Coloureds, Indians and Whites respectively. Furthermore, and according to the South African Community Epidemiology Network on Drug Use (2010(b):17), there is an increase in admission of Black/African patients who were using heroin and the figure has increased to 54% from a previous 47% in the period from January 2009 to June 2010 in Gauteng. This tendency is confirmed in this research.

3.2.4 Place of residence

Seven of the participants were from Gauteng, one from the Northern Cape and one from Ekangala (Mpumalanga). The place of residence of the other three participants was unknown.

3.2.5 Highest educational qualification

Five participants did not state their highest educational qualifications and the researcher also failed⁴ to enquire about these. Two participants stated that they had completed Grade 12. One of them also started a course in Introduction to Law which he did not complete. One participant dropped out of school prior to obtaining his matric and one participant held a tertiary qualification (i.e. she is a chartered accountant). Another two participants mentioned that they were qualified boiler makers and one was a fire-fighter. According to Tuten, Jones, Lertch and Stitzer (2007:552), in their study focusing on aftercare plans of inpatients undergoing detoxification, they found that the majority of drug abusers in their study had a high school education or less. This differs somewhat from the findings about highest educational qualifications in this study as some of the participants had completed high school, and one had tertiary qualifications. This can be supported by statistics from South African Community Epidemiology Network on Drug Use (2010:4) as it states that three quarters of

⁴ This oversight is seen as a limitation by the researcher.

the patients who attended treatment centres from January 2006 to June 2010 had completed their secondary education (Grade 8-12), 15% their primary education and 8% had tertiary education.

3.2.6 Employment status of the participants

Apart for the participant who is a fire-fighter and one who is a chartered accountant and who will both return to their places of employment upon leaving the treatment centre, and two participants whose employment status is unknown, the rest are unemployed. The large number of participants being unemployed corroborates the finding in the study done by Tuten et al. (2007: 50 & 552) in which 91.2% of participants were unemployed while two-thirds of the participants indicated a desire for help with finding a job after treatment.

3.2.7 Number of times being admitted to rehabilitation centres

For five participants this was their first admittance to a treatment centre. Another five participants were at a treatment centre for the second time and two participants were admitted for the third and fourth time respectively.

3.3 Summary of biographical information of participants

Under this heading a brief summary of some of the biographical information for each of the participants will be provided.

PARTICIPANT A:

The participant is a female of almost 26 years of age. This was her first admission to a rehabilitation centre. Her parents were divorced when she was 16 years old. She stayed with her mother after the divorce. She told the researcher that she has a better relationship with her father than with her mother, but also mentioned that her father had raped her from the age of six until she was 14. The relationship between her and her mother had improved over the past three years.

PARTICIPANT B:

The participant is male and 25 years old. He was previously admitted to Castle Carey and to Vista before his admission to DFFRTC. He came from a family of seven children of whom he was the only boy and also the youngest child. He was the only one still staying with his mother. His father left the family. Three of his sisters are married; the other three are single and staying on their own. He has no relationship with his father.

The participant is the father of three children, two girls and a boy. The children were staying with his mother while he was admitted to DFFRTC.

PARTICIPANT C:

Participant C is male and 20 years of age. He was first admitted to a rehabilitation centre when he was 15 years old and had already been admitted to three previous rehabilitation centres. His parents were divorced when he was twelve years old. He stayed with his mother for about a year until she received a promotion at work and moved to the Eastern Cape where she is still residing. The participant moved in with his maternal grandfather who took care of him since then. He had a strong relationship with both his mother and grandfather, but not with his father who is in the employ of the Department of Correctional Services.

PARTICIPANT D:

Participant D is male and 24 years old. He had been admitted to a rehabilitation centre for the second time. He is a fire-fighter at the City of Tshwane, where he was suspended conditionally, in terms of which he would resume duties upon successful completion of treatment. The participant comes from a family of six members: his father, his mother, himself and three sisters. Two of his sisters are older and one younger than himself. The participant described his family as loving and made mention of the fact that he was the only one with a dependency problem.

PARTICIPANT E:

This participant is male and 25 years old. This was his first admission to the DFFRTC rehabilitation centre. He also went to a rehabilitation centre that is on a farm and run by the

Catholic church and he stayed there for a period of three weeks after which he left the farm before completing the treatment programme. He comes from a family consisting of parents, a big brother and a young sister. His niece and nephew stay with the family. The participant has a good relationship with his mother, but the relationship with his father is strained.

PARTICIPANT F:

Participant F is female and 20 years of age. This was her first admission to a rehabilitation centre. At home she stays with her mother and siblings in Kimberley, Northern Cape. Her father, with whom she did not have a good relationship, has passed away. Her one uncle and her grandfather (who have both passed away) were the actual father figures in her life.

PARTICIPANT G:

This participant is male and 28 years of age. It was his first admission to a rehabilitation centre, although he had attended an outpatient centre before. He comes from Soshanguve, Gauteng, where he stays with his family. His family comprises his mother, three sisters and himself. His father passed away. He has a good relationship with all his family members and also had a good relationship with his late father.

PARTICIPANT H:

Participant H is a 19-year old female. This was her first admission to a rehabilitation centre. She attended SANCA meetings before being admitted to the DFFRTC. The participant comes from a caring family consisting of father, mother and sisters. Her relationship with her father, who was also drug dependent, is described as the best relationship she has with all her family members, although she also had a good relationship with her mother.

PARTICIPANT I:

Participant I is a 22 year old male. He was admitted to the DFFRTC for the second time. The participant and his brothers were brought up by his grandmother and after she passed away he stayed with his maternal aunt. His mother was deceased and had had an alcohol addiction problem. His father left the family when the participant was still a small boy and stayed in

Tzaneen. There was no relationship between the father and son and he had not seen his father in many years.

PARTICIPANT J:

This participant is female and 31 years of age. This was her first admission to a rehabilitation centre. She was referred to the DFFRTC by the court, due to her addiction problem. The participant comes from a family consisting of her mother and two sisters. She also has three sons. The participant, her children, as well as one of her sisters stay with her mother. At home all the adults are struggling with dependency (the mother used prescribed medicine and the other sister used heroin).

PARTICIPANT K:

Participant K is male and 29 years of age. This was his first admission to a rehabilitation centre. The participant's father is deceased and he stays with his mother with whom he has a close relationship. He is an only child.

PARTICIPANT L:

This participant who is male and 21 years of age was admitted to a rehabilitation centre in Moreleta before his admission to the DFFRTC. The participant is an only child and grew up in a stable, happy family with both his parents. The parents' expectations of him are very high.

3.4 Presentation of the themes, sub-themes and categories deduced from the analysed data and the consensus discussion

The themes, sub-themes and categories that emerged from the data analysis and the consensus discussion between the researcher, the independent coder and the study's supervisor are depicted in the table below.

TABLE 3.2 THEMES, SUB-THEMES AND CATEGORIES		
THEMES	SUB-THEMES	CATEGORIES
<p>THEME 1: The addiction history of participants.</p>	<ul style="list-style-type: none"> • Substance of choice - types of substances abused by participants. • Participants' experiences of previous rehabilitation centres. • Participants' reasons for relapse. • Participants' reasons and motivations for present admission to DFFRTC 	
<p>THEME 2: Participants' self-perceptions: past, present and future.</p>	<ul style="list-style-type: none"> • Participants' perceptions about their old selves. • Participants' perceptions about their new selves. • Participants' perceptions about their futures and future plans. 	
<p>THEME 3: Family situation of participants: past and present.</p>	<ul style="list-style-type: none"> • Family composition of participants. • The nature of the family's relationships with the participants: past and present • Participants' past relationships with their fathers and mothers Participants' past relationships with their siblings and other family members 	
<p>THEME 4:</p>	<ul style="list-style-type: none"> • Participants' perceptions about going back to 	<ul style="list-style-type: none"> • Negative perceptions and feelings about going back to

<p>Perceptions, expectations and fears of participants about being reintegrated into their family systems</p>	<p>their families</p> <ul style="list-style-type: none"> • Aspects that excite participants about going back to their families • Participants' fears about being reunited with their families. • The families' expectations of the participants 	<p>the family</p> <ul style="list-style-type: none"> • Positive perceptions and feelings about going back to the family • The participants are excited about the fact that they can prove to their families that they have changed • The participants are excited about the fact of being reunited with their family and friends again • The participants are excited about the fact of getting out of the rehabilitation centre and starting a new life • Participant fear that they will relapse • Participants fear that their families will distrust them • Participants fear the impact of their environment on them • Participants would be expected to regain the family's trust • The families will expect participants to make good choices about their future • The participants expect their families to accept and trust
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	<p>following their treatment: The participants' perspectives</p> <ul style="list-style-type: none"> • Participants' expectations of their families and need for assistance in relation to being reintegrated back into the family system • Perceived challenges in view of being reunited with the family 	<p>them again and need assistance in this regard</p> <ul style="list-style-type: none"> • The participants expect and need their families to give them love and support • The participants expect and need to bond with their families again and have a need to spend quality time together • The participants expect and need practical help and financial assistance from the family • The participants expect and need their families to get educated on the topic of addiction • Participants have a need for family members to accompany them to aftercare services • Participants face challenges around their peer groups following reunification with their families • Participants face the challenge of filling free-time • Participants face the challenge of being dependent on the family again
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<p>THEME 5: Support needs of participants directed to the DFFRTC and social workers about being reintegrated into their family systems</p>	<ul style="list-style-type: none"> • Participants' support needs from DFFRTC and social workers • Participants' perceptions on what will ease their integrating back into their families 	<ul style="list-style-type: none"> • Participants need individual sessions and personal support from social workers at the DFFRTC • Participants need aftercare services in the community in collaboration with the DFFRTC • Participants need more activities at DFFRTC • Participants need more contact with parents and family during rehabilitation • Participants are aware that they have to take certain actions themselves to ease their integration • Participants need letters to state that they attended school during rehabilitation
<p>THEME6: The experiences of participants during weekend leave</p>	<ul style="list-style-type: none"> • Persons with whom the participants spent their weekend leave and the activities they engaged in • Temptations participants encountered during the weekend leave and participants' reaction to the former • Relapse during the weekend leave 	

In the next section of this chapter each of the themes with its related sub-themes and categories (where applicable) will be presented by providing storylines to substantiate each of the aforementioned. The themes, sub-themes and categories (where applicable) will (where possible) be subjected to a literature control.

3.4.1 Theme 1: The addiction history of participants

This theme was sub-divided into the following sub-themes which will be presented one after the other in the next section of this report:

- Substances of choice - types of substances abused by participants.
- Participants' experiences of previous rehabilitation centres.
- Participants' reasons for relapse.
- Participants' reasons and motivations for present admission to DFFRTC

3.4.1.1 Sub-theme: Substances of choice - types of substances abused by participants

The table below provides an overview of the types of substances abused by the participants:

TABLE 3.3: SUBSTANCES OF CHOICE – TYPES OF SUBSTANCES ABUSED BY THE PARTICIPANTS

Type of substance abused	Number of participants	Type of substance abused	Number of participants
Cocaine/Rocks	8 participants	Cat (Methcathinone)	3 participants
crystal methamphetamine/tik	2 participants	Ecstasy	3 participants
Heroin	6 participants	Mandrax/ dormutil,	4 participants
Other*	4 participants	Dagga	6 participants

**Other: Acid, glue, alcohol and "anything".*

According to Gouws, Kruger and Burger (2008:214- 219), drugs are classified into six groups namely: depressants, narcotics, stimulants, inhalants, relaxants (euphorians), and hallucinogens. **Depressants** such as mandrax/dormutil, barbiturates, sleeping tablets and alcohol depress the central nervous system and in small doses they act like tranquillizers to

relieve anxiety and tension (Gossop, 2007: 154). According to Gossop (2007:156), mandrax and dormutil are regarded as the same thing hence they are used together in this research. **Narcotic** drugs such as heroin are powerful depressants that induce calmness and are effective pain killers (Gouws et al., 2008:216). **Stimulants** (i.e. crack/cocaine, crystal methamphetamine), as the name indicates, stimulate the central nervous system (Gossop, 2007:147). **Inhalant** substances such as petrol, paint thinners, and glue are inhaled as chemical vapours and produce mind-altering effects (www.thefreedictionary.com). Dagga or cannabis falls in the category “**relaxants**” (**euphorians**). Dagga is classified as “hallucinogen” by some researchers while others have classified it as “euphorians”, because dagga contains properties of depressants, stimulants, narcotics and hallucinogens and for this reason is classified differently by different researchers (Gouws et al., 2008:220). **Hallucinogens** are drugs such as LSD (lysergic acid diethylamide), PCP (phencyclidine) and mescaline. Individuals taking such substances experience changes in sensory perceptions, euphoria and disoriented mental behaviour (Gouws et al., 2008:221; Bezuidenhout, 2004: 120).

All the participants in the study used more than one substance; however Table 3.2 was used to indicate how many participants used a given substance and is explained as follows:

- Eight participants mentioned cocaine as their drug of choice. According to South African Community Epidemiology Network on Drug Use (2010(b):2 & 5) apart from alcohol, the most common primary substance of abuse was cocaine; moreover in Gauteng the most common secondary substance reported by heroin patients was cocaine/crack. Cocaine induces a sense of euphoria and it makes users more talkative, argumentative, relieves feelings of depression, increases alertness and makes the user feel intelligent and in control of the situation (Gouws et al., 2008:218).
- Heroin was indicated as the substance of choice abused by six participants. This high percentage of heroin use is supported by statistics from South African Community Epidemiology Network on Drug Use (2010 (a):2) which indicate that admissions in Rehabilitation Centres for treatment for heroin have increased in Gauteng. Furthermore, Gouws et al. (2008:217) state that heroin is becoming a number one drug for youth in South Africa because it is cheap. Heroin is a drug that suppresses pain and clouds mental functioning; however it is very addictive because it creates physical dependence (Gouws et al., 2008:216).

- Six participants used dagga. When one looks at this research all six participants used dagga with other substances (see Table 3.1). In the South African Community Epidemiology Network on Drug Use (2011:2) it is noted that of the 2684 admissions to 17 treatment centres recorded in the first half of 2010, the most common primary substance of abuse was cannabis (dagga). Dagga releases a feeling of euphoria, as well as tension and anxieties; however its effects depend on the dose of a certain chemical in the dagga called THC (tetrahydrocannabinol). Mild doses makes the user talkative, relaxed and cheerful, but heavier doses increase the intensity of sensory experiences and impair coordination, judgment and can induce hallucinations (Gouws et al., 2008:220-221).
- Four participants used mandrax/dormutil. With reference to this drug, Gouws et al. (2008:215) note that South Africa is rated as the country with the largest number of mandrax abusers in the world. Mandrax slows down the activity of the central nervous system, and if taken in small doses relieves tension but in higher doses it produces staggering, impaired thinking, slurred speech and slow reflexes (Gouws et al., 2008:216).
- Three participants described their substance of abuse as ecstasy. According Gossop (2007:127), ecstasy is a difficult drug to categorise as it falls between hallucinogens and stimulants as it lead to changes in the state of consciousness in higher doses and leads to changes in emotional states – that is why it is called the “love drug”. On the other hand it induces a pleasant easily controllable emotional state with relaxation and a feeling of happiness.
- Three participants gave their substance of abuse as methcathinone, and according to South African Community Epidemiology Network on Drug Use (2011:2) in Gauteng the proportion of patients who reported methcathinone (‘CAT’) as a primary drug of abuse remains higher than in any of the other provinces, but decreased from 2% to 1%. ‘CAT’ has effects not unlike methamphetamine but is considered not quite as powerful hence in this research there were only three participants who reported having used it.
- Two participants told the researcher that crystal methamphetamine/tik was their substance of choice. With reference to crystal methamphetamine/tik, Gouws et al. (2008:219) state that crystal methamphetamine/tik is the latest popular drug in the drug circles in South Africa and it is becoming increasingly popular amongst school

children. In this study the contrary was true as only two participants indicated having used the drug. Crystal methamphetamine/tik is a highly addictive drug that releases a high level of dopamine which stimulates brain cells, and then it gives an extremely pleasurable rush which is short lived and followed by euphoria. Users feel extremely energetic and can stay awake for hours and seldom feel hungry (Gouws et al., 2008:219).

- Four participants used other substances such as glue, alcohol and anything else. According to the South African Community Epidemiology Network on Drug Use (2011:1-2), alcohol remains the dominant substance of abuse across all sites; it was reported that 28% in the Western Cape and 70% in the Central Region (which comprises the Free State, Northern Cape and North West) of patients in treatment have alcohol as a primary drug of abuse. The use of inhalants among young people continues to be an issue across sites, although the number of patients reporting inhalants as their primary drug is low.

Almost all the participants used more than one substance. This is supported by South African Community Epidemiology Network on Drug Use (2011:5) as it was discovered that poly-substance abuse also remains high, with 25% reported in the Central Region (which comprises the Free State, Northern Cape and North West) and 43% in the Western Cape of patients in specialist treatment centres reporting more than one substance of abuse. Karjalainen, Lintonen, Impinen, Lillsunde and Ostamo (2010:150) state that the literature confirms the fact that poly-drug findings are common, and have been common elsewhere too. For instance poly-drug use was highly prevalent in Sweden during 2001–2004: 58% of the drug positive cases had a finding of multiple drugs, including alcohol. Similarly in Switzerland multiple drugs including alcohol were found in 62% of the suspected cases during 1982–1994. In Norway multiple drugs were detected in more than 60% of the drug positive samples analysed in 1995. In Finland during 1977–2007 poly-drugs were found in 77% of the suspected cases and thus seemed to be higher than in those other countries. The following storylines testify to poly-substance abuse amongst the participants interviewed in this study (**please note that the participants' statements as transcribed have been left as rendered with no attempt to edit or correct the language usage**):

“I was using coke, cat, ecstasy; it was my drug of choice, but basically anything you put in front of me I will have used.”

“Beside nyaope (heroin) I used rocks, crystal meth, I didn’t use it like over dose I used it when I have money because that drug makes you to wanna chase more, chase more and you end up not having nothing.”

“I was using dagga, Heroin, Ecstasy, Rocks and Cat.”

3.4.1.2 Sub-theme: Participants’ experiences of previous rehabilitation centres⁵

Some of the experiences shared by participants concerning their previous admissions to rehabilitation centres are depicted in Table 3.4 below:

TABLE 3.4: PARTICIPANTS’ EXPERIENCES OF PREVIOUS REHABILITATION CENTRES

Castle Carey: Vista:	<i>“I was in rehab for six weeks and, I stayed clean for nine months.”</i> <i>“Vista is like a holiday inn.”</i>
Stabilis:	<i>“I did a 35 day program then I went out. I stayed two and half weeks clean without using.”</i>
Catholic Church farm:	<i>“I have been into previous rehabilitation centre, like a catholic church type of a thing where we were like I a farm based, we were not smoking, there the was strict rules but I never lasted there. I only stayed there about three weeks and I left the place. “</i>
SANCA:	<i>“It was an outpatient thing because you go there in the morning and they give you medication and then you stay in the sonar for some time and later around four (pm) you go back home.”</i>
DFFRTC :	<i>“This is my second time that I have been admitted in Magaliesoord Rehabilitation Centre... [the] first time I was admitted I was admitted through the court I was arrested for house breaking and theft.”</i>
Private rehabilitation Centre in Moreleta Park, Pretoria	<i>“That side you can get drugs like easily rather than here at Ribeiro you can’t just smuggle drugs.”</i>

⁵ A rehabilitation centre in the context of this study refers to a public or private facility that offers intensive treatment and rehabilitation to service users addicted to chemical substances (Prevention of and treatment for Substance Abuse Act, Act No. 70 of 2008).

3.4.1.3 Sub-theme: Participants' reasons for relapsing

Reasons given for relapsing⁶ were mostly projected on other people and external circumstances (see storylines below). None of the participants took responsibility by admitting that it was a choice they made.

For instant **Participant C** blamed his relapse on friends when he stated: *“The mistake I made is I went back to the friends I had... eventually they convinced to use again.”*

Participant D blames having money available after coming out of the rehabilitation centre as what caused him to relapse. He shared the following in this regard: *“I was fully paid when I was there and when I got out of Stabilis my bank account was fat you see, so the other thing was having money and nothing to do with the money, ja, that is why I smoked”.*

Participant E blamed his environment as dagga was cheap in his neighbourhood and this lead to his relapse: *“Dagga is just R3,00 or R5,00 so you don't go out of your way or struggle to get dagga, so I just smoked dagga and using alcohol so that is what got me into this situation.”*

The literature states that people who have substance abuse problems tend to use defence mechanisms to provide reasons for and covering-up the substance abuse problems and/or to justify their relapses (McNeece & DiNitto, 1998:91). Some of the defence mechanisms deduced from the storylines above point to denial (denying the chemical abuse and addiction) and rationalisation. Rationalisation refers to providing reasons to explain or excuse the chemical abuse and relapse. The chemically dependent person can also use projection as a defence mechanism. In this instance the chemically dependent person blames others and external circumstances for his or her addiction and relapse (McNeece & DiNitto, 1998:91). The storylines quoted above do not only provide reasons for the participants' relapses but also relate to the projection and rationalisation as defence mechanisms employed to justify the relapses. Tuten et al. (2007: 552) in their study found that returning to a familiar drug using environment could be an important factor contributing to early relapse in patients who were leaving a detoxification programme unit and returning to their familiar drug-using

⁶ The term “relapse” means “the return to the uncontrolled alcohol or drug use following a period of abstinence” (Fischer & Harrison, 2005:156).

environment. The reference made by the participant that dagga was so available and cheap in his neighbourhood corresponds with this reference to a “familiar drug-using environment” fuelling a recovering drug and alcohol patient’s chances to relapse.

Participant I perceived his personal family situation, friends and his unstable mind as reasons for relapse and articulated himself as follows: *“I have changed that time but the time I went out it was so difficult for me to stay sober, my friends what can I say my mind was not clear, I was still thinking about substance and those family matters I came across so I went back to my old road again. It was little bit hard for me without parents you know doing it yourself and looking at my friends and say look at nice clothes they wear I have nothing and I have to stand on my own, asking my aunt and them.”*

In latching on to the train of thought about “family matters” that the participant came across after the in-patient treatment that caused him to relapse. Gorski (in Fisher & Harrison, 2005:158) is of the view that coming from a dysfunctional family⁷ can result in self-defeating personality traits and disorders which can increase the risk of relapsing.

Participant K blamed his failed relationship with his girlfriend for his relapse and stated: *“See ... I don’t want to be in a relationship right now because I realised one thing is I relapse because of a relationship”*. This failed relationship with a girlfriend as cause for the participant’s relapse is echoed by Fisher and Harrison (2005:169) when they state that “relationship problems are a cause of many relapses”.

Participant C also blamed cravings and boredom for his relapse and spoke about this along the following lines: *“Yee also the withdrawals and because of having nothing to do actually, you know after a certain treatment centre like the third one I went to when I came out I just dropped out of school and it was already late for me it was during the world cup seasons”*,

Linking up with the quotations from participants above about their reasons for relapsing, Ramo and Brown (2008:377) came to the following conclusions after studying two classes of relapse patterns in both adolescents and adults with important differences between the age groups. Two-thirds of the adults relapsed in social situations in which they experienced urges

⁷ The participant comes from a family background where his mother had a history of substance addiction and his father abandoned them.

and temptations to drink/use chemical substances. One-third relapsed as a means to cope with a negative emotion and also urges and temptations to drink/use chemical substances. In contrast, most adolescents relapsed in social situations when they were trying to enhance a positive emotional state, while a smaller group of adolescents relapsed when dealing with a conflicting interpersonal situation accompanied by negative emotions and efforts to cope with urges and social pressures to drink/use chemical substances.

3.4.1.4 Sub-theme: Participants' reasons and motivations for admission to DFFRTC

Participants were admitted to the DFFRTC for various reasons, which varied from being sentenced for breaking the law to voluntary admission. According to the Prevention of and treatment for Substance Abuse Act (Act No. 70 of 2008:38-44), application for admission as a voluntary service user to a treatment centre can be made by any person, any person acting on behalf of the voluntary service user or a parent or guardian of that child if the voluntary service user is a child. Also a court convicting a person of any offence may in addition to any sentence in respect of such offence order that such person be committed to a treatment centre if the court is satisfied that such person is a person who is dependent on substances; is a danger to himself or herself or to the immediate environment or causes a major public health risk; does harm to his or her own welfare or the welfare of his or her family and others; or commits a criminal act to sustain his or her dependence on substances.

The following storylines give an indication of the participants' reasons and motivations for their admission to DFFRTC:

"I got arrested 2008 and I was arrested until 16 November 2010, and that is when I got admitted to this rehab."

"Section 40⁸, on free will ... on my own without my parents knowing."

"More about it, I have been working for the City of Tshwane or the senior fire fighter in the City of Tshwane, but due to my addiction I started not performing well at work and they needed me to come clean before I resume my duties."

⁸ Referring to Section 40 in the Prevention of and treatment for Substance Abuse Act (Act No. 70 of 2008).

“One of my sisters took me to SANCA to meet with my Social Worker from outside ... then after 3 months they told me that they are going to bring me here in Magalies, so I agreed.”

“I stole things in a warehouse ... obviously you start getting greedy ...the third time someone tip them off and got caught, so I ended up going to court.”

3.4.2 Theme 2: Participants’ self-perceptions: past, present and future

This theme was deduced from the information provided throughout the interviews by the participants and no specific question in this regard was specifically directed to the participants.

3.4.2.1 Sub-theme: Participants’ perceptions about their old selves

The following utterances provided a glimpse of the negative perceptions of the participants had of themselves and what they thought others thought of them while they were abusing chemical substances. They saw themselves as “failures”, “destructive” and being the black sheep in the family, as the following storylines testify:

“I messed up my whole life and I broke my family’s heart.”

“I use to love school, I was a good learner and the teachers loved me, but when I started drugs I use to dodge school during lunch and not do homeworks.”

“I am the black sheep of the family at the moment.”

“I was working, I had this and I had that and then I lost everything back to square one.”

“You use to wear nice clothes, your father bought you a car and you had a nice girlfriend. So now all that is gone.”

“Sometimes I hated myself. I even had suicidal thoughts whiles I am drugged; just feeling that life is not treating me nicely.”

These negative self-perceptions harboured by the participants while they were abusing substances were confirmed by a study conducted by Schäfer (2011:140) in that most of the 12 participants reported that they “felt that they had no self-esteem when they were in active addiction”.

3.4.2.2 Sub-theme: Participants’ perceptions about their new selves

Some of the participants’ utterances provided glimpses and insight into how they perceived themselves at the end of the rehabilitation period. They indicated that they had changed and that they felt positive about their new selves. Rogers (in Du Toit *et al.*, 2003:68) confirms that individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided. The following storylines testify to the estimates they placed on themselves at the end of the treatment:

“I will accomplish what I want because I know I can do it”.

“I know myself. As from now I have decided that no more drugs; it is just going to take my life backwards”.

“I mean obvious for the three months I have been here I have changed from the person who came in I am not the same person.”

3.4.2.3 Sub-theme: Participants’ perceptions about their future and future plans

The participants indicated that they wanted their lives to get on track once they leave the rehabilitation centre. This is supported by Hansen, Ganley and Carlucci (2008: 268) in their study on the recovery of chemically dependent patients as the participants began to gain an understanding of who they were without the disguises and secrets. There was hope for a new way of life that could be sustained, as behaviours were modified, commitments were renewed and strengthened. The following storylines are provided in support of this sub-theme:

One participant indicated that he wanted to move to a new environment to allow himself to make a fresh start: *“I am thinking about the advice I got of going to another environment where people don’t know you, then you start to make new friends and a new life.”*

Six of the participants shared their hopes of finding work or to further their studies:

“To go back and start my own life, obviously to find a job, because I have mitigation behind my name because I am using drugs. It might cause me not to get work.”

“I will go to school there or a job... I just don’t want a job that will be just a job that will keep me busy. I want a job whereby is a career, something that I will be interested in and I will be looking forward when I wake up in the morning, saying I am going to work.”

“I want to be an accountant; I use to do commercial subjects.”

“Get myself a job or ... join aftercare classes.”

“I am an accountant termed as CA, ahh hopefully I will be having my job when I come out I just have to speak to my boss after all this.”

“There’s another friend of mine he has just got shares into this restaurant its, it’s like a restaurant so I’m going to be working there but we are still going to decide probably his assistant manager or something so the prospect is looking good at the moment”

This sub-theme signifying that participants are unemployed and wish to have a fresh start by getting a job, is supported by a study done by Tuten et al. (2007: 550 and 552) in which 91.2% of their participants were unemployed and two-thirds of the participants indicated a desire for help in finding a job after treatment.

Furthermore, three of the participants indicated that they wanted to do “something good” with their lives. This ranged from writing their story for a future generation to launching drug campaigns. They spoke about this along the following lines:

“Let me say write something about my life, like what you are doing now I could memorize everything from my childhood and have a file, when I read it my tears could come out you know ... So I can have a story to tell my children that if they are 15 I say once in life this kind of people changed me.”

“I want to start a drug awareness campaign. I want to start an NGO when I get outside I am really passionate about drug awareness.”

“Going out and helping other people ... I will be like a light for the world yaa.”

To conclude this sub-theme it must be mentioned that other participants indicated their future plans in more practical ways concerning their personal situations. They wanted to be successful, buy houses, settle down and start caring for family members. The following storylines are provided in confirmation of this:

“Obviously I am turning 26 and I want to settle down... Maybe going out there, having my own children in the near future.”

“It is my turn now to look after her [mother]; she is becoming old now so I need to start looking after her before she gets to pension. As soon as I start working I need to save money, I will look after her [mother] my whole life. I want to start making the money and buying my own house.”

3.4.3 Theme 3: Family situation of participants: past and present

This theme was deduced from the information provided by the participants on the question posed to the participants to tell the researcher more about their families. Based on the answers provided this theme was subsequently divided into four sub-themes which will be presented in the discussion to follow.

3.4.3.1 Sub-theme: Family composition of participants

This sub-theme provides insight into the family composition of the various participants. When one looks at the literature on the family systems theory it describes or explains the family in terms of boundaries, forcing, and sub-systems (Saatcioglu, Erim & Cakmak, 2006:125). The boundaries are permeable and within the system the sub-systems are more or

less fluid and function together as a basic structural unit or nucleus for the family members. Sub-systems may consist of individuals, dual groups, triads, or more (i.e. the couple sub-system, the parent-child sub-system, the children as sub-system and the sibling sub-system and the individual sub-systems.) When a change occurs in one part of a sub-system it has an impact on the other parts of the system. Cook (2001:154) explains this as follows: “As with any system, the smallest change in any part of the family [seen as a system] is felt by all the members of the family and requires an adjustment of behaviour.” When a change occurs in one part of the system attempts are ignited towards the reorganisation of the system in order to establish and achieve a relative stability. Saatcioglu et al. (2006:125) postulate that the system has to adapt to stress, and transform in a reactional manner. The system can resist transformation, is capable of arranging, adjusting, and restabilising itself (homeostasis). Reaction of the system to transformation and stress involves flexibility of various degrees. Cook (2001:154-155) notes that in a healthy differentiated family, the reactions and adjustments to change are made with a minimum of anxiety, but in the less-differentiated family the adjustment to change is more anxiety-provoking and difficult. This anxiety is expressed as a loss of function or dysfunction. The norm is to perceive one member of the system as the “one with the problem” or “the sick one” and as the anxiety in the family increases the symptom-bearer becomes more symptomatic. The system is naturally divided in a horizontal (i.e. brotherhood) and vertical (various generations) manner (Saatcioglu et al., 2006:125). From the accounts of the participants about their family position the research concluded that six of the 12 participants interviewed originated from non-intact families.

Two of the participants shared that their parents were divorced. Both participants’ parents were divorced while they were in their adolescent years. They both stayed with their mothers after this, although participant C later moved in with his maternal grandfather; the following storylines confirm this:

“They got divorced while I was 16. My mother [raised me] and we did not see my father for about 8 months he was out of the picture for a while.”

“My mother and father divorced, I think I was twelve. I have been raised by a single mother and we are not even living together. I am currently living with my grandfather which is my mother's father.”

Four participants indicated that they had lost a parent through death. Three lost their fathers and one lost his mother. The tragedy is that the participant who lost his mother (Participant I) also had no relationship with his father, who had left the family when he was still a small boy. They spoke about this along the following lines:

“And now I live with my mother, my father passed away.”

“Well I only got my mother my father passed away, so it is just me and my mother right now.”

“My mom passed way the year 2001 she was very sick. My dad left me in 2000 he is staying in Tzaneen, the time he realized that my mother was sick he was like staying away from us, he left me...”

Although the aim of this study was not to investigate family composition in relation to adolescents' substance abuse, it is significant that Paxton, Valois and Drane (2007:594) refer to the consensus about the fact that children from non-intact families have more problems than those with both parents (real or adoptive). While the literature cited by the aforementioned authors implies that children from non-intact families are more likely to smoke cigarettes and engage in the use of alcohol and other illicit substances, Paxton et al. (2007:603) found in their study investigating the relationship between family structure and substance use in a sample of 2138 public school students in a southern state in the USA that intact families cannot simply be labelled as “at-risk” families who amongst others are responsible for introducing children to substance use.

While Participant J shared that she had lost her father, she also made mention of the fact that her mother and sister were also both addicted to substances when she said: *“My sister is a heroin addict and my mom has problem with pills she is a prescribed medicine addict.”*

Although this participant was not requested to indicate the influence of her mother and sister's addictions on her own addiction, most of the 12 participants in Schäfer's (2011:138-139) study stated that their parents were addicted to alcohol and other substances and they had some belief that this caused them to become addicted to chemical substances. One participant in the study referred to stated that his family is “littered” with alcoholism and apart from him being addicted his brother had passed on as result of a drug overdose. Henry,

Robinson and Wilson (2003:44) in a study on adolescents' perception of their family system, parents' behaviour, self-esteem, and family life satisfaction in relation to their substance use, amongst 214 high school students at two high schools in a south-western state in the USA, confirmed the former train of thought in that they found that parental substance use was directly related to adolescent substance use.

When looking at the participants' family composition in terms of having siblings, or being an only child, the following information came to the fore. Some of the participants had siblings, but three of the participants were the only child in their family and were boys. Another three of the participants were the only boy in their family. This accounts for 50% of the participants who were either the only boy, or the only child.

In conclusion of this sub-theme, it may be mentioned that two of the participants are parents themselves. Both participants are still staying with their mothers

“My family is my mom and my 2 sisters and I have 3 children of my own and at home it is just me and my older sister. They (boys) all live with me, well my mom is looking after them at the moment while I am here.”

“(At home) it is just my mother and (my) three kids and a baby sitter, she is babysitting my baby boy who is now turning two years and the other two are going to school.”

3.4.3.2 Sub-theme: The nature of the family's relationships with the participants: past and present

The participants' accounts (provided in the table below) point to the fact that they and their respective families and members in the families had negative past relationships, but this has in general changed considerably during the time the participants were in the rehabilitation centre.

Table 3.5: THE NATURE OF THE FAMILY'S RELATIONSHIPS WITH THE PARTICIPANTS: PAST AND PRESENT

PAST RELATIONSHIPS	PRESENT RELATIONSHIPS
Participant A: <i>“Me and father we were the close ones and me and mother never had a relationship.”</i>	Participant A: <i>“Me and my mother are getting along now we are close for 3 years or so.”</i> Participant A: <i>“I am sure they love me because they are here every weekend.”</i>
Participant B: <i>she [referring to his mother] disowned me from the family. She left me in prison, I phoned her repeatedly, she didn't want anything to do with me, she couldn't believe that I went so far as to murder someone,</i>	Participant B: <i>at the end of the day she [referring to his mother] came through for me. I got shot six times you see and she came to the hospital and they helped me because my mother is matron at the hospital you see, she nursed me, she told all the other nurses to stay away from me, she will make sure nee she cured me you see, she did just that she spent most of the time in my bedside and when I woke up my mother said to me my child you been in this thing for a long time, we are talking now almost eight or nine years ago.</i>
Participant F: <i>“I have disappointed my family a lot during that stage when I was on drugs.”</i>	Participant F: <i>“They are nice people but they haven't given up hope on me because I am always in their prayers and they always knew that I will come right.”</i>
Participant H: <i>My sisters they always like to criticize, they don't like to listen before they talk, they never gave me that time to talk to them because I have been raped in 2008 that is the reason why I started using drugs because I was lacking they were not I did not listen, they grew up being straight and I am not like them, so they are the ones who made me use drugs, they never motivated</i>	Participant H: <i>Now it is better [referring to the relationship] because one of my sisters is the one who brought me here.</i>

<i>me you see then I ended up losing my self esteem</i>	
<i>Participant L: “They are disappointed and our relationship because of me smoking using substances it is not that good but they try not show that side, they try to show me the support rather than criticize and things like that.”</i>	<i>Participant L: “It is a good relationship because even though I am here they still support me big time.”</i>

Although the aim of this study was not to indicate how relationships with the family of origin influenced the participants’ propensity towards substance abuse, the most salient finding in Schäfer (2011:137 & 139) study was that all 12 participants in her study referred to the fact that they had experienced abusive and difficult relationships with their parents throughout their childhoods and felt unable to develop functional relationships with their family of origin or their current family members. The participants also identified a strong connection between these dysfunctional family relationships and their substance abuse (Schäfer, 2011:137). This finding is also confirmed by Haines and Case (2005:169-170).

3.4.3.3 Sub-theme: Participants’ past relationships with their fathers and mothers

Eight of the participants indicated that they had a strained relationship with their fathers, and only one participant had a good relationship with her father. When one looks at the relationship with their mothers six of the participants had good relationships with their mothers before they went for treatment. These relationships were mostly still intact during the treatment period, whereas five participants shared that their relationships with their mothers were not good, but for three of them the relationship had improved, while one participant’s mother passed away. The other participant still had a strained relationship with her mother. This information is supported by the findings of the research study by Schäfer (2011:137 and 139) referred to above and by a study done by Emmelkamp and Heeres (cited in Saatcioglu et al., 2006: 129) in which it was found that fathers showed much more disapproval and lack of emotional warmth to their children who have a substance abuse problem, whereas mothers showed excessively protective attitudes towards their children who have a substance abuse problem. Linking with the findings, Henry et al. (2003:32) state

that the literature confirms the fact that parental support and control relate indeed to illicit adolescent substance use. Youth whose parents had a warm, close and supporting relationship with their children and who employed logical reason as a means of control, refrained and/or used alcohol more sensibly than those who perceived their parents to be authoritarian, indulgent, or neglecting. The following storylines are provided in support of this sub-theme and the discussion above:

“I don’t want to speak about that nigger [referring to his father]... Me and my father have a bad relationship. My dad was never around for me ... I think if he was there for me more things would have been different, so that is why me and him don’t speak to each other anymore and it’s been eight years now, we live in the same place and we pass each other like we don’t know each other.”

“Me and father we were the close ones and me and mother never had a relationship.”

“She [referring to his mother] came to the hospital and they helped me because my mother is matron at the hospital you see, she nursed me. I am the only son she had and she always used to give me more attention to me than my sisters. Me and mother’s relationship and now it is stronger than ever.

“My relationship with my mother is good. As I have said, I think I have disappointed her. She did not have powers to talk to me about drugs I was using. She would just say, ‘my son I pray for you that one day you could leave these things you are using and come and assist me with the family business and looking after your sisters’ ... I was the only man left at home to support my mother, but I didn’t care about that.”

“We had our ups and downs. I use to fight with my mother and it is not something I am proud of or something. Now me and mother, since my father my grandfather is dead I think it brought us back together.”

3.4.3.4 Sub-theme: Participants’ past relationships with their siblings and other family members

Only one participant described his past relationships with his siblings as good. He still maintained the relationships while he was in the DFFRTC. Five participants had problematic

relationship with their siblings before they were admitted to the DFFRTC. Two of these indicated that the relationships improved while the other three did not really comment on any changes in the relationships. Five of the participants mentioned relationships with other important family members in their lives. Two participants mentioned that they have good relationship with their grandparents and always got good advice from them. Some participants mentioned family members like uncles and aunts who do not trust them as they lied and stole from them and they do not have good relationship with them. Bezuidenhout (2004:127) states that when addiction becomes more prominent in the life of the individual and begins to control his/her life there is a tendency to withdraw from all previous relationships, because the person finds it difficult to simultaneously maintain and satisfy the need for substance and family relationships. Many addicts find it difficult to cope with and perform according to the expectations of the family members as they may try to hide their addiction which may cause conflict in the family and lead to aggression or result in an addict leaving home. With reference to the effect of a sibling's illicit drug addiction on non-using siblings, Webber (2003:233-236) in her study on the impact of illicit drug use on non-using sibling in the Vietnamese community found that the sibling's illicit drug use has the following consequences for the non-using siblings:

- The non-using sibling (especially when younger) may take over the responsibilities of the using sibling with the effect of losing something of their own childhood and adolescence in order to help the family to cope with the crisis.
- The non-using siblings are losing out on the parents' quality time and attention as they are focused on the drug-using child. This may result in a situation where the non-using children spent more time away from home.
- The non-using siblings may develop a conflicting relationship with the using sibling and deeply resent the latter for bringing disgrace, hurt and disruption to the family. The non-using siblings become angry towards the using-sibling for inflicting pain in the family and causing the former to become stigmatised by their peers.
- The using-sibling prevents the family and non-using sibling from engaging and attending family gatherings and rituals as they fear that the using-sibling might disappoint and embarrass the family.

The following storylines are provided as substantiation of this sub-theme:

“I went to stay with my one sister, my younger sister in town, I stayed with my sister for two years still busy with gangsterism and my sisters and them they always supported me I don’t know why they stood by me. They still believe in me.”

“Me and my sister we were not on speaking terms. You know how sisters are. They would put you down rather than uplift you.”

“My sisters they always like to criticize, they don’t like to listen before they talk. I felt I was alone, I felt like I deserved it as they say ... Their talks couldn’t hurt me when I smoked, I just ignored their talks. Now it is better because one of my sisters is the one who brought me here.”

“My grandfather always supported me and he still believed in me.”

“Some of my cousins I have hurt them a lot. I don’t think they have forgiven me yet, but I just have to gain their trust again. My uncle was a father figure in my life and my grandfather.”

3.4.4 Theme 4: Perceptions, expectations and fears of participants about being reintegrated into their family systems

This theme was deduced from the information provided by the participants regarding the following questions:

- What are your perceptions about going back to your family?
- What excites you about going back to your family?
- What are your fears about going back to your family?
- What do you think your family expects from you after completing your treatment?
- What do you expect and need in terms of assistance in relation to your integration back into the family system?
- What do you perceive to be your challenges in view of being reunited with your family?

The answers provided to each of these questions were subsequently organised as sub-themes to be presented in the next section of this chapter:

3.4.4.1 Sub-theme: Participants' perceptions about going back to their families

Perceptions of participants about going back to their respective families varied from being positive to negative. This led to the following categories being derived from the data collected:

- Negative perceptions and feelings about going back to the family
- Positive perceptions and feelings about going back to the family

These categories are now again discussed storylines taken from the transcribed interviews.

- **Category: Negative perceptions and feelings about going back to the family**

Some of the participants had negative perceptions and feelings about going back to their families because their families criticise them, treat them like addicts and they do not trust them. Howard, Heston, Key and Mccrory (2010:473) concur that addiction in the family can clearly compromise family relationships, often leading to enormously strained interactions. Substance users are often judged more harshly than other family members, resulting in compromised relationships. In support of the aforementioned, the following storylines:

“If they could stop criticizing because they like to criticize, they can make you feel down.”

“They must stop treating me like an addict.” [Indicating the need for trust].

“I would say my opinion is that I would like my mother to stop drinking.”

“I am scared because I am going home and my older sister is there and there is heroin ready available at the house you know, it is there 24/7 because of my sister.”

“Most of the girls that are going home they've got their moms and dads they don't have that temptation there, I am walking right into it.”

“If I have to come here then they must send my sister to come here then that temptation is not there when I get home.”

“If they don’t act as if I was an addict that will make me feel more comfortable you see.”

“They mustn’t be afraid to leave me with their purse and when they want to go they must just go they mustn’t have stress that they are going and that they are leaving me in the house, they must be free because I have changed.”

- **Category: Positive perceptions and feelings about going back to the family**

Six of the participants had positive perceptions about their families as they mentioned that they were nice people and so they were feeling positive and looking forward to re-joining them again at home. Some even mentioned that the family was looking forward to seeing them. As a matter of fact some of the participants’ families had already organised employment, a place to stay and financial assistance. In confirming this category and the information provided above the following storylines are relevant:

“You know I think they are very nice, I have a very nice family and I thank God I hope everyone had a family like mine, ja, like now I will be discharging on a Friday and I gave them a call yesterday they have a lot of things arranged for me outside, things I never asked for, things I never thought they will arrange for me and it is very nice of them and it is thoughtful of them, it shows that they love me and now I have to show that love back”

“Back to them will be quite nice to reunite with them again, even be there for family gatherings again.”

“I think they will treat me fine, I think they will understand me better.”

“Family is where you belong you see that is where your heart is. “

“Just to be with them, just to show them that I can be the new (person) that I was before I used.”

“They have a lot of things arranged for me outside, things I never asked for, things I never thought they will arrange for me and it is very nice of them and it is thoughtful of them. It shows that they love me and now I have to show that love back. I never asked for any of those things, but it is nice that they did that.”

The same sentiments shared by the participants above in relation to perceiving and feeling positive about returning home after treatment are supported by the research done by Turner et al.(2010:72) stating that prior to discharge, participants expressed feelings of excitement at the prospect of returning home.

3.4.4.2 Sub-theme: Aspects that excite participants about going back to their families

The following aspects (to be presented as categories in the discussion below) excite the participants about being reunited with their families.

- The participants are excited about the fact that they can prove to their families that they have changed
- The participants are excited about the fact of being reunited with their family and friends again
- The participants are excited about the fact of getting out of the rehabilitation centre and starting a new life
- **Category: The participants are excited about the fact that they can prove to their families that they have changed**

The participants wanted their families to see that they have changed. They were proud of their achievement at the DFFRTC and were looking forward to showing this to the world outside. The following utterances are provided in support of this category:

“I can show them that I am the person I was and that they know and I am still who I am you know, I did bad things but that is not who I am but it just the ways I had.”

“To show them that I have changed (laughing) ya that is what excites me to show them that I have changed I am no more a druggie.”

“I am excited a lot because now I am going back to my family being a sober person after a long time and stay with my family as a happy person.”

- **Category: The participants are excited about the fact of being reunited with their family and friends again**

Participants were looking forward to being reunited with their families again. Eight of them commented that they were longing for their families and felt excited about going back to them again. Some of the utterances made in this regard are:

“My kids, just before I got arrested I spent a lot of time with them, just the most thing I’m looking out for. Spending three hours with them here in the visitors park is not enough time, putting them to bed at night, I want to be, I want them to be the first thing I see in the morning when I wake up, this I used to do before I got arrested that is what I’m excited about the most.”

“I am going to see them [referring to her family] after a long time, after three months not being with them. They are also going to be excited to see me I know.”

“Being with them [referring to his family] and then let them know that I love them and whatever that I did I didn’t do it purposefully and I am always there for them.”

“Seeing my boys, seeing my boys, being able to tuck them in bed, being able just to be with them, I waited 3 months for this you know, preparing them for school, making their lunch, all those things I couldn’t do this last 3 months you know, just blooming in the sun with them watching a movie, making up for the 3 months I have lost out.”

“Especially my mother is goner accept me with both hands.”

Friedman et al. (in Saatcioglu et al., 2006:129) concluded that substance abusers often see themselves as being emotionally disengaged rather than being emotionally tied to their families. This is confirmed by Bezuidenhout (2004:127-129) when indicating that, as the addiction intensifies, there is a tendency to withdraw from previous relationships as the addict finds it difficult to simultaneously maintain and satisfy the urge for substances and for intra- and extra-familial relationships. The author further explains that adolescents who abuse

substances or who are addicted to them tend to run away from their homes. This is most evident in homes in which parents are not interested in the plight of their children, or are not able to handle the situation constructively, or where these children are in need of an environment in which they can maintain their drug-centred lifestyle. The literature referred to above is supported by what participants stated in the interviews as they said they were spending less time with their family and now that they are drug free they would want to bond with their families again as they had been disengaged from them during their use of substance.

- **Category: The participants are excited about the fact of getting out of the rehabilitation centre and starting a new life**

The participants were looking forward with excitement to starting a new life upon exiting the rehabilitation centre and shared feelings of happiness and freedom as they will be able to enjoy things like as driving and shopping – activities that they could not engage in while in rehabilitation. In confirming this category, the participants (i.e. patients who suffered brain injury) in Turner et al.'s. (2010:76) study compared the hospital environment to a prison-like environment in that they felt confined and controlled. They viewed the home environment as a symbol of freedom and perceived returning home as an opportunity to regain the life that had been lost. The participants in the above study also expressed feelings of happiness about going home as this would enable them to enjoy simple pleasures like playing with the children, going for a walk, or listening to loud music.

In support of this category the following storylines are provided:

“Well I’m not really excited about going back to my family I’m more excited of getting out into the real world and, and getting on with my life.”

“Shopping spree, I like clothes, I like clothes with my whole heart.”

“Driving again, very exciting, I haven’t been driving for a while looking forward to it.”

3.4.4.3 Sub-theme: Participants' fears about being reunited with their families

On the question of what participants fear about going back to their families, answers revealed that their biggest fears were of relapsing and losing the trust of their families and having to work on trust again. Some fear the impact of the environment on them, while how to deal with the family at home was also expressed as a fear by some of the participants. The mentioned fears will be presented (as categories) in the discussion to follow:

- **Category: Participants' fear that they will relapse**

Four participants frankly shared their fear of relapsing as they do not trust themselves; some of these participants mentioned that they are scared of triggers. They referred to this along the following lines:

"I am just scared, well I am afraid of myself for maybe what I will do to them, and maybe I will relapse and hurt them again and disappoint them."

"A relapse starts there most of the time you go drinking alcohol and then while your drinking alcohol you realize that you are not getting the same drunkenness."

"Just that I am scared that I will relapse."

"My fear is me relapsing honestly speaking."

Witkiewitz and Bowen (2010:362) in writing about relapse prevention refer to numerous risk factors that are associated with relapse. These include craving or urges, interpersonal stress, lack of motivation, self-efficacy, and ineffective coping skills in high-risk situations.

- **Category: Participants fear that their families will distrust them**

Participants feared or were worried that their families would not accept that they have changed. Families will test them to see if the change is holding and this will break down trust. The reason for the family's prevailing distrust towards even the rehabilitated chemical

substance abuser can be attributed to the fact that the relationship between the former and the family based on past experiences is founded upon and characterised by deceit, stealing, broken promises and dishonesty (Jackson et al., 2007:324). Linked to this train of thought, Rogers (in Meyer, Moore & Viljoen, 2002: 378) states that individuals might sometimes in their lives experience non-acceptance by significant others and will feel worth only when they have fulfilled certain conditions laid down by the significant others.

In support of this category, the following storylines are provided:

“My fear is them [referring to the family] not accepting that I am a different person that is my only fear. If I go back home and they still treat me like before I came to rehab, that will turn me off. “

“The trust wouldn’t be the same anymore ... I am not sure if they will offer the trust they use to offer before the substance and staff.”

“I want them to have trust in me, I know my family is supportive they just want me to be clean, I know that they were very disappointed in me and they are not going to trust me.”

- **Category: Participants fear the impact of their environment on them**

Some of the participants shared that they were scared of going back to their old environments where friends would either react negatively, or try to tempt them to use substances again. They referred to this along the following lines:

“I am going back to the same environment you know.”

“Going back to friends, you know it will start by grooving alcohol.”

“They might think that I am the same person so my friends will influence me to go back to drugs that are what I fear.”

“[Pheew] ...I have fears of going back home, not with my family, my family I don’t have fears with them. I am scared that when I go back home someone provokes me

and when I am not with my family and something like that, I am scared I'm goner do something I'm goner regret."

"The bad aspect, a friend of mine ja who I actually want to distance myself because, that one there I can relapse very quickly so don't want to be close to him anymore."

"The biggest fear will be in my community, maybe if my family want to choose friends for me and say this one is right that one is not right, maybe they [referring to the community] might think that I still am with the same friends that I had before."

In underscoring this category and the accompanying storylines, Park et al. (2009:50) point to several studies indicating that adolescents with friends who use alcohol are more likely to use alcohol themselves as engaging in a relationship with a delinquent peer group enables adolescents to maintain an accepting perspective on substance use, which in turn increases acceptance and participation in risky behaviours. Furthermore Park et al. (2009:50) refer to a study that was undertaken by Kandel et al. more than 30 years ago pointing to the fact that peer pressure is a strong predictor of risky behaviours such as substance use as it was found that pressure from a best friend had the strongest effect on substance use. Tuten et al. (2007: 552) postulate that returning to a familiar drug-using environment could be an important factor contributing to early relapse in patients who were leaving a detoxification programme unit.

3.4.4.4 Sub-theme: The families' expectations of the participants following their treatment: The participants' perspectives

Although no questions in this regard were specifically asked, some of the participants provided insight into what they thought their families would expect of them when they re-joined their families again.

Two categories emerged from the data in relation to this sub-theme:

- Participants would be expected to regain the family's trust
- The families will expect participants to make good choices about their future

- **Category: Participants would be expected to regain the family's trust**

The participants felt that they would have to regain their family's trust and prove to them that they have recovered from their addiction. The following storylines articulate this perceived expectation:

"I have to gain their trust."

"Here I got a second chance to show them that I can be a better person and that I can do it for myself."

"I just have to prove myself then I am pretty sure things will be ok as long as I don't go back to the drugs."

"Sit on the table talk to them and ask them for forgiveness for what I have done."

"The expectations from my family will be: Are you really, really over that stuff?"

"I am going to prove to some of them that I am clean and I am prepared to make things right."

"I have to prove myself so that when I go to my mother's bedroom she doesn't have to wonder if she left her jewellery box on the dressing table."

This perceived expectation that the family might harbour for the participants to regain the trust of the family is due to the fact that the family members felt betrayed by all the lies and deceit from the drug-using family member and concluded that they cannot blindly trust him/her (Jackson et al., 2007:324). However, as much as the participants have wronged their families and betrayed their trust, they need to be given a second chance to remain sober.

- **Category: The families will expect participants to make good choices about their future**

Two participants' perceptions were that their families would expect them to make good choices about their future according to the family values. They spoke about this along the following lines:

“They expect me to be clean ... and stay away from bad friends ... no alcohol and stuff ... And going to church regularly.”

“They expect me to go to college in time, studying, taking all the opportunities, taking life seriously ... and find a nice man now. Volunteer in community programs, going to the library, read books and stuff.”

3.4.4.5 Sub-theme: Participants' expectations of their families and need for assistance in relation to being reintegrated back into the family system

This sub-theme focusing on what the participants' expect and the assistance needed from their families after being reunited with them ties in with the previous sub-theme. The information provided by the participants in relation to this sub-theme divided into the following categories to be addressed in this section of the chapter.

- The participants expect their families to accept and trust them again and need assistance in this regard
- The participants expect and need their families to give them love and support
- The participants expect and need to bond with their families again and have the need to spend quality time together
- The participants expect and need practical help and financial assistance from the family
- The participants expect and need their families to become educated on the topic of addiction
- Participants have the need for family members to accompany them to aftercare services

- **Category: The participants expect their families to accept and trust them again and need assistance in this regard**

The participants expect and need their respective family members to show them that they trust them by not referring back to the past and by staying positive about the change they underwent at the rehabilitation centre. The issue of not trusting the drug-using family member and the need to be trusted following the former's treatment is imperative for the drug-using family member on his road to sobriety and recovery (Jackson et al., 2007:324). Insight must be created in all parties concerned on how they arrived at the situation of not trusting each other and strategies need to be devised to assist with building up the trust between the rehabilitated drug-using family member and his/her family. However, as much as they have wronged them they feel they need to be given a second chance to prove that they have changed, which is supported by Rogers quoted by Meyer et al. (2002: 369) stating that people have a need for positive self-regard which requires the trust and approval of others in order to feel positive and believe in oneself.

In support of this category the following storylines are provided:

“They must talk openly with me tell me where I stand, what they expect from me not walk around egg shell not wanting to talk in front of me because they are scared that I will relapse, just be open and honest.”

“Just to treat me as a normal person.”

“I expect they can start to trust me a bit more seeing that I have been here for 3 months.”

“I expect them not to take me like a criminal or a druggie, they can trust me and they can put faith in me that you are changed.”

“Facing my mom, facing my sister. Not knowing what they are thinking you know or expecting from me. How they are going to treat me or how must I treat them, are they going to treat me under locking tree for the rest of my life.”

“I know that they don’t trust me but they don’t have to show it to me. The thing that will hurt me most is when they dig out old graves.”

“Stay positive and not always giving me negative feedback. Trust me, just give me that.”

“I need the trust to come back more than anything because that is the hardest thing because trust when is lost is hard to be regained again.”

“Just to be themselves and not concentrate that [referring to the participant’s substance abuse] much on me.”

“They need to give me the benefit of the doubt.”

“If they can try to listen to me because I know I am a right girl. Stop listening to people, because they like listening to people and people can talk many wrong things.”

- **Category: The participants expect and need their families to give them love and support**

Participants reiterated the fact that they expect and need the love and support of their family members. Park et al. (2009:50-51) quoting several authors, point to the fact that youths with greater parental support tend to participate in fewer negative anti-social behaviours. This predictive relationship can be explained against the backdrop of the social control theory which states that close relationships through social support can have a positive influence on adolescent drinking. This theory emphasises that parental support has a mitigating effect on negative peer influence. Hammerbacher and Lyvers (2006:388) concur by stating the factors associated with relapse among clients in Australian substance disorder treatment facilities as being family dysfunction and low social support. Henry et al. (2003:48,53) further elaborate when stating that parents can fulfil a protective function, not only in lowering the risk of substance abuse, but in preventing the rehabilitated drug-using child from relapsing when they provide the necessary support characterised by encouragement, praise and physical affection. The participants articulated their expectation of and need for the families’ love and support along the following lines:

“Love and support, love me the way I am and support me more.”

“I expect them to be just there for me all the time and just encouraging me and motivating me again and not give up hope on me.”

“I expect their love, to show me the way.”

“Help me gain my self-esteem, help me gain myself confidence. I expect love from them. They must try to make me feel like a change person.”

“[Being] non-judgmental and really listen to what I am trying to say when I talk to them.”

“If they notice anything good about it and then talk about it, if they say I will like it because now you do one, two, and three keep it up then I will do it again.”

“I need a support system, I need someone I can rely on, someone who is not goner judge me or put me down when I say I am craving I feel like this stuff.”

“I don’t need a lot from my family what I need is their love and warmth.”

“I want them [referring to the family] to show that you are our child, love and trust and try to build some relationship. They must show concern.”

- **Category: The participants expect and need to bond with their families again and have the need to spend quality time together**

The participants expressed the need to bond with their families and spend quality time with them. Friedman et al. (in Saatcioglu et al., 2006:129) postulate that substance using family members often see themselves as being emotionally disengaged rather than being emotionally tied to their families. This is confirmed by Bezuidenhout (2004: 127-129) where he indicates that as the addiction intensifies, there is a tendency to withdraw from previous relationships as the addict finds it difficult to simultaneously maintain them and satisfy the urge for substances and for intra- and extra-familial relationships. The above author further explains

that adolescents who abuse substances or who are addicted to them tend to run away from their homes. This is most evident in homes in which parents are not interested in the plight of their children, or who are not able to handle the situation constructively, or because these children are in need of an environment in which they can maintain their drug-centred lifestyle. This is supported by what participants stated about spending less time with their family but now that they are drug free wanting to bond with their families as they were disengaged from their families during their use of substances. They articulated their expectations and need in this regard as follows:

“I want that bond that I had with my family.”

“If we can sit like a family and talk about anything.”

“Sit down and talk to me, so that we can both sit down and I can express how I feel about my situation going home.”

“I just want them to be more into my life.”

“It is a good thing that I will live with my mother because we can share quality time together and there is no need to come back this side.”

“Maybe on Sunday go to church together again. And also on weekends sitting with them and talking to them and telling them what happened, what happened during the week.”

“I want them to be with me more, spend more time with me go out with them all the time you see be more like a family again.”

“Maybe we can start communicating again because I haven’t communicated with them I don’t know when how many months I just far away from them and I didn’t wanna tell them anything about my life what is happening in my life.”

- **Category: The participants expect and need practical help and financial assistance from the family**

Practical help expected from participants varied from financial help, help in finding a job to assistance with informing other family members that the participant is now a changed person.

This need for assistance in helping some of the participants to find a job is confirmed by Tuten et al. (2007:552) who undertook a study about the aftercare plans of in-patients undergoing detoxification, and found two-thirds of the participants in this study indicated a desire for help with finding a job following detoxification. This is an encouraging finding, since finding and being gainfully employed are viewed as an imperative part on the journey towards recovery, and have been associated with good or improved outcomes in drug abuse treatment patients. Furthermore, returning drug abusers to the workforce would be a highly desirable outcome and could positively impact the overall cost-effectiveness of drug abuse treatment. The participants expressed the need for practical and financial help as follows:

“I think the thing they will do most is they will try to find me a job ... Just to help me until I am on my feet. Helping me with my kids still until I find a job and helping me looking for a job.”

“I really want to go back to school, I want to change my life, I have bigger dreams if they could assist me with payments.”

“I must get a cell phone so that I could get back to technology. At least I must get a computer to put me out of this world you see and I think those gadgets should have them.”

“Maybe even some financial support because there is a possibility that I have another friend of mine who is in IT so we want to start another IT company, so we might need to buy equipments and hire premises.”

“And also inform other family members that I worked with when I grew up and in school and those who know that I was involved with drugs try to make them aware that I am change person and I am ready to take over the family business as many of them wanted me to.”

“Help me to deal with my financial problems.”

- **Category: Participants expect and need the family to become educated on the topic of addiction**

One participant expressed the need for his family to learn more about drug addiction and articulated this as follows: *“They need to be educated about addiction because if they are they won’t blame me about the past, no they will blame the addiction not me.”* To quote the participant: *“The thing is education about addiction will answer every question about reintegration.”*

The following storylines express the need from the participants’ side for social workers to educate their respective families about addiction:

“Explain further about addiction and what is addiction, how addiction works, how we can manage sobriety of your child who was dependent and that he is not doing it on purpose.”

“Social Workers can help a lot by giving my family light of a person who is being in a rehab centre.”

“Just like they are teaching me about relapses they (family) also need it because it also affect them not just me.”

This is supported by Saatcioglu et al. (2006:125) stating that it seems an important requirement that the clinician involves and maintains the presence of the family in its entirety in the treatment process. A family often needs as much treatment as the family member who is the abuser of alcohol or a substance. In this regard, the participation of the family (as group members) in the treatment process is paramount and by assuming a supportive role the members of the family are assets in terms of preventing relapse, and extending clean time, and also very important for solving conflicts that give rise to abuse of alcohol or substances. This need for being educated about substances and addiction was also expressed by the participants in Webber’s study (2003:239) where Vietnamese mothers and a cohort of non-using siblings were interviewed to investigate the impact of illicit drug use on non-using siblings.

- **Category: Participants have the need for family members to accompany them to aftercare services**

Some of the participants indicated that they would like their families to attend aftercare services with them in order to support them and to understand them better. Quotations from the transcribed interviews pointing to this are:

“By coming with me to support groups.”

“They should like go to a drug seminar of some kind whereby they will learn about drugs and then understand that everything I did or most of the things I did I did them because I was an addict.”

“If one of them, when I come out of this place I want to attend support group, if one of them can come with me to listen what addict come from.”

“Maybe come with me to the psychologist. I would like them to come to the support groups, so that they can have a deeper understanding.”

“Like going with me to the support groups, even though they might not go with me but when I come back they must ask me.”

“If my mom could be in some of my sessions so that she know what is like.”

This category and supporting storylines are affirmed by Saatcioglu et al. (2006: 125) stating that it seems an important requirement that the clinician involves and maintains the presence of the family in its entirety in the treatment process. A family often needs as much treatment as the family member who is the abuser of alcohol or a substance. In this regard, participation of the family in the treatment process as group members and by assuming a supportive role are assets in terms of preventing relapse, and extending clean time, and also very important for solving conflicts that give rise to abuse of alcohol or substances.

Upon being reintegrated with the family, one participant expressed the need for the social worker at the Centre to have aftercare contact with the family. He stated this as follows: *“If there was an open line between my Social Worker and my family I think it will make it a*

whole lot easier, like a Social Worker checking up how is this patient. I think this Social Worker too they must interview our parents to find out how is the relationship at home.”

Tuten et al. (2007:551) in supporting the importance of aftercare participation in ensuring the sober long-term prognosis for drug abusers treated in detoxification settings, found that virtually all participants surveyed (98%) claimed that they had plans to participate in some form of aftercare following their residential detoxification. Percy, Thornton and McCrystal (2008:382) endorse the participants’ need for family members to accompany them to aftercare and point out that the family (especially the parents) should be involved in the treatment engagement. Furthermore, in families containing multiple alcohol and drug users, interventions aimed at any single individual may be ineffective. Steinglass (2008:10) elaborates on the former train of thought when stating that there is growing evidence that engaging the family and family-focused treatment approaches to chemical dependence enhance the drug using family member’s changes to engage and remain in treatment and improve the treatment outcomes for all parties involved. Steinglass (2008:11-12) maintains that the active involvement of the family during the assessment/diagnostic phase of the treatment helps to provide a clear clinical picture around the nature, frequency and impact of the abuse on the abuser and the family. Furthermore, that involving both the patient and the family in on-going treatment (i.e. during rehabilitation and aftercare) substantially improves the long term outcomes for both the patient and the family.

3.4.4.6 Sub-theme: Perceived challenges in view of being reunited with your family

The participants’ responses substantiating this sub-theme correspond with the sub-theme focusing on the fears harboured about being reunited with the family. This sub-theme was divided into various categories to be presented in the next part of this chapter.

- **Category: Participants face challenges around their peer groups following the reunification with their families**

Four of the participants saw their previous friends as a challenge. They told the researcher that their friends would try to get them back on substances. One participant shared that his challenge would rather be that his family would try to choose friends for him. They referred to this challenge as follows:

“My peer groups I know that when I come back they are going to try to get me in the corner.”

“Friends have a mentality that as drug users we bring one another down. When I came back from that other rehabilitation centre I would sit in the presence of them and they will smoke, but I wouldn’t smoke because I had that will power to say no. But as time goes on, pressure comes from both sides, you know. Then you relapse again.”

“If they could stop choosing friends for me I am old now I know what is right and what is wrong, I know good friends and bad friends, I have been there.”

In support of this category about the peer groups posing a challenge to the participants’ sobriety on returning back to the families, Van der Westhuizen (2010:138) refers to Falkowski who postulated that poor social skills (especially the lack of being assertive) and the affiliation with chemical substance-using peer groups can maintain addiction and cause relapses to occur. Jarvis et al. (in Van der Westhuizen, 2010:140) maintain that being assertive is a valuable skill to enable the recovering chemical abuser to deal with the temptations of the peer group.

- **Category: Participants face the challenge of filling free time**

Two of the participants were worried about how to fill their free time as they would get bored. Bezuidenhout (2004:66 &71) states that if the community or residential area lacks recreational, educational and sports facilities or does not have sufficient amenities to meet their demands the youth are likely to get bored and therefore they are more likely to consume alcohol. The author further states that the South African home environment has changed so much as there is an increasing influx of working mothers, single parent families and unemployment which forces parents to look for work far away from home and leave adolescents alone, which means adolescents spend time with their peers and less time with their families and this therefore exposes them to risky behaviours. On the other hand, Walter quoted by Dube (2007:30) states that chemically dependent adolescents gradually change their peer group to include drinking and drug-using friends. Furthermore, Van der Westhuizen (2007: 87) came to the conclusion that the participants in her study did not have a

plan to explore a new lifestyle that is drug free as they also mentioned that they were bored at home. The participants spoke about the challenge of killing free time and being bored as follows:

“Boredomness is goner get me.”

“Weekends are going to be the challenges, as during the week I will be busy in classes or so. Weekends a person can’t just sit still, especially if you are young.”

- **Category: Participants face the challenge of being dependent on the family again**

Three participants referred to facing the challenge of being dependent on the family again whilst wanting to get to a stage of functioning independently, and expressed themselves as follows in this regard:

“I was independent now I am suspended from work without any source of income so I have to be dependent again.”

“Because of them wanting me to do what they want me to do now they are putting an eye on what I am doing ... continue with what I want to do, because if that doesn’t succeed they will be disappointed and in their minds they will tell themselves using of drugs is the thing.”

“I think the challenge that I have is to prove to them that I wanna live my own life and do things for myself.”

The storylines above are supported by a study done by Shivy, Wu, Moon, Mann, Mann, Holland and Eacho (2007:471) where participants not only described the specific needs that they have but also their concerns about and awareness of relying on others for help which made it difficult to be independent. This is further elaborated by Bezuidenhout (2004:128) where he states that individuals whose lives have become alcohol and/or drug centred find it difficult to keep their jobs and once their superior knows about the nature of their problem they may lose their job. This might result in psychological, social and economic consequences for the individual and his family. Furthermore, if the individuals are attending school they may be asked to leave school voluntarily or can be expelled which may have

negative consequences for their future life prospects. Therefore this might create dependency as the individual does not have the resources to look after him or herself.

3.4.5 Theme 5: Support needs of participants directed to the DFFRTC and social workers about being reintegrated into their family systems

This theme was deduced from the information provided by the participants in reply to the following questions:

- How can DFFRTC support you in respect of successful integration with your family?
- How can the social workers assist you in respect of successful integration with your family?

These questions were each handled as a separate sub-theme, like the previous section, and the following summary and storylines resulted from the content of the interviews with the participants.

3.4.5.1 Sub-theme: Participants' support needs from DFFRTC and social workers

On the question of what participants need from the DFFRTC when going back to their families, it became clear that participants had a need for more individual sessions and aftercare services. They also wanted their families to be part of the rehabilitation process. These aspects will be presented as categories in the following section of this chapter.

- **Category: Participants need individual sessions and personal support from social workers at the DFFRTC**

Some participants had the need for individual sessions apart from group sessions and one of the participants felt that they needed personal support from social workers. Participant A also suggested that a session be held together with the family to do an assessment. They articulated their needs in this regard as follows:

“Do a session with you a week before a patient is due to be released and to get everybody relaxed and comfortable with each other again and to see if it is going to be ideal for the patient to go back to the environment.”

“What I think is needed here is we need more individual sessions and less group sessions.”

“If they could try and give us one on one sessions yaa that could help, because sometimes you become afraid talking in a group because when you go out some of them will go and tell other what you said in the group.”

“Encouraging me and giving me hope. Make it clear to me that everything is going to be fine.”

“How to manage problems and situations in order not to relapse.”

“You will find someone he wants to smoke at the time and now the Social Worker is not there. There should be a substitute if the Social Worker is not here they should be someone who is substituting if she is not here.”

According to Tuten et al. (2007: 552), in a study about the aftercare plans of in-patients undergoing detoxification, individual counselling emerged as the highest priority service, being stated as desirable by 73.5% of the participants. Given the predominance of group counselling within community substance abuse treatment, it is of interest that individual counselling received this high endorsement as a higher priority service. This is contrary to what is happening at the DFFRTC where the participants are engaged in only group sessions and have articulated the need for individual sessions.

- **Category: Participants need aftercare services in the community in collaboration with the DFFRTC**

Participants suggested that a proper aftercare programme be introduced into the communities in collaboration with DFFRTC. In view of the importance of aftercare participation in long-term prognosis for drug abusers treated in detoxification settings Tuten et al. (2007:551) found that virtually all participants surveyed (98%) claimed that they had plans to participate in some form of aftercare following their residential detoxification.

The following storylines are provided in support of this sub-theme:

“They can have out-patient sessions with my family once a month or two months or they could have somewhere to meet with the social workers and asked us about the challenges and how things are at home.”

“And then the other thing is aftercare ... The Social Development in every Province or every branch should have a support system, a support group of its own because CAD and Narcotics Anonymous how am I going to get there?”

“Just to tell my family to be strong and we attend classes in our community and make sure that I don’t relapse and in my family give them information about a person who is from a rehab centre and maybe encourage them to support me.”

- **Category: Participants need more activities at DFFRTC**

Two of the participants suggested that the rehabilitation centre should develop more activities. They feel that there is not enough to do and that they became bored during their free times. They referred to this along the following lines:

“You can get bored in here beside drama there is nothing to do, if they could try and arrange more activities ... Soccer, choir, netball, teach us swimming because some of us don’t know how to swim, learn new things so that when you go you can show the outside people that you know this and this and that I have learned something.”

“Focus more on the different activities because most of us here, when it comes to talent and stuff there is not much support in that ... they must encourage more extra mural activities.”

In support of this category and pointing to the value of engaging in various activities at an in-patient treatment facility, one of the participants referred to in an article entitled: Alcoholism and drug abuse weekly (2011: 2) shared his experience about attending a treatment programme at the Life Healing Centre in Santa Fe, New Mexico. He described the treatment experience as “full and rich”. “They encouraged us to take part in the more beautiful things that life has to offer, like hiking or horseback riding”, he said. “To have the opportunity to enjoy life while the brain is normalizing helps people look forward to a life of recovery”.

- **Category: Participants need more contact with parents and family during rehabilitation**

Participants would have liked their families to be part of their recovery process while at DFFRTC and also indicated that they would like their families to receive feedback on their progress. They stated:

“They would have helped if during my 3 months program there was a time where they have called in my parents and give them some kind of education about addiction.”

“If they could allow our parents to come and see when we perform, there are many activities here I am doing drama and I didn’t notice that I was good in acting.”

“They must keep in contact with our families and let them know what is going on because them keeping quiet for 3 months is not helping. At least if the Social Workers were communicating via the family we will get a whole lot more rehabilitation because people are always phoning home all the time, they get visit they speak to their families, so if the family member could say you know what why where you not participating tell me what is wrong maybe that person will be able to open up.”

This is supported by Gruber et al. (2001:268) stating that several studies focusing on the involvement of families in the recovering process have shown that individuals are more likely to relapse when family members are not involved in the treatment activities (such as counselling, educational and self-help programmes). Furthermore, when families are participating in the recovery process of a substance abusing individual they are more likely to be supportive than to “sabotage” the recovery process of the substance abusing individual. The involvement in the recovery process by family members also benefits the family members as they learn about addiction and its physical, psychological and emotional effects.

3.4.5.2 Sub-theme: Participants’ perceptions on what will ease their integrating back into their families

Apart from the support of the family, the attitude of trust displayed towards the participants by the family and the family being educated on the topic of substance abuse and aftercare

services (discussed previously in this chapter), the participant mentioned the following that will ease the integration back into the family:

- Actions taken by the participants themselves
 - Letter to state that participants attended school. This will now be discussed.
- **Category: Participants are aware that they have to take certain actions themselves to ease their integration**

Some of the participants felt that they were responsible for reintegration with their families. Rogers quoted by Du Toit et al. (2003:68) confirms that individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour. Participants indicated that they want to develop a sense of self and be the best they can be by staying positive and being focused.

“Just staying positive that is it, not let anyone break me down, I will be fine like that.”

“Just not lying and telling the truth if I have a problem.”

“Be clean for the rest of my life and going out and helping other people it will more better for me because people will look up and say ‘Ja, that is not the same person we know.’”

- **Category: A participant’s need for a letter to state that he attended school during rehabilitation**

Participant H had a need for a letter to state that he had attended school while he was at the rehabilitation centre and referred to this as follows: *“If they could give me a form to show them to give it to them to take me back to school... if they could give us group work or some kind of a task to show them that I was busy there I was not sitting and doing nothing.”*

3.4.6 Theme 6: The experiences of participants during weekend leave – a unique theme

This was not a question put to all participants. The information gained from the responses of the participants who did talk about their weekend leave⁹, can however be significant and is thus discussed here. Storylines are classified under the following sub-themes:

- Person(s) with whom the participant spent the weekend;
- Reaction to possible temptation; and
- Relapse during the leave weekend.

3.4.6.1 Sub-theme: Persons with whom the participants spent their weekend leave and the activities they engaged in

Most of the participants went home to their families for their weekend leave while one went out only for a day and another participant spent the weekend at a friend's place. The following storylines refer to this:

“Yeah the whole weekend I spend it with my grandfather. Unfortunately my mother came on a Saturday because she used the bus from Cape to Pretoria ... Unfortunately on Sunday I have to come back to the institution. We did not talk much but we talked.”

“It is like I said I don't want to go to the environment that I was before, I didn't go home. My sister came and we went to Menlyn to shop and I came back.”

“It was nice nee, I saw a couple of people that I wanted to see some friends of mine they have gone far in life once again.”

“We [mother and the participant] fought constantly.”

⁹ Participants qualify for weekend leave when they have spent eight weeks at the centre and the reason is to see if they can cope outside without using substances and also to see if they are ready to face the outside world when they are discharged in the 12th week.

3.4.6.2 Sub-theme: Temptations participants encountered during the weekend leave and participants' reaction

Participants admitted that the challenges of using substances do exist. The following three participants discuss their experiences in this regard.

"I'm not too sure what are my triggers yet, I haven't had any during my leave and I didn't take anything during my leave and it was in front of me and I haven't taken anything."

"It was a nice weekend leave but it put everything in perspective about what I must do when I am finished here. There was a challenge there was a bad aspect friend which I saw there it almost tempted me so I decided to dodge him, but he is bit of a bad aspect that one so I think I have got to watch out for this bad aspects in life because they are always going to be there."

"That (peer pressure) is one of the experiences I even faced when I went on leave. Not to say you don't wanna use. At the end of the day it is your choice if you wanna use."

In support of this sub-theme, Witkiewitz and Bowen (2010:362) refer to several studies that state that numerous risk factors that appear to be the most robust and immediate predictors of relapse are negative effects, cravings or urges, interpersonal stress, motivation, self-inefficacy, and ineffective coping skills in high-risk situations.

3.4.6.3 Sub-theme: Relapse during the weekend leave

Participant J shared the story of her relapse during her weekend leave and stated: *"Like in my weekend out she [referring to her mother] already presumed I am going to relapse, I am going do it again and she has no faith. I relapsed on my weekend out, I say to myself if I didn't get it right in 8 weeks how I 'm I going get it right in 4 weeks when I get out of here you know and that really scare me a lot. Then I thought to myself when I go back I'm going to test positive, so I decided to myself I wasn't going come back then I went to go buy some stuff Sunday night."*

In underscoring this sub-theme and the accompanying storyline Hammerbacher and Lyvers (2006: 391) in their study conducted in Australia about factors associated with relapse among clients in Australian substance disorder treatment facilities found that the most common type of reason given for relapse was negative mood states (61.5%), with far fewer subjects citing external pressures (17.3%), desire for positive mood states (12.5%), or social/family problems (8.7%).

3.5 Conclusion

This research project aimed to explore and describe the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system. In order to achieve the goal and objectives of this research as described in Chapter 1, 12 interviews were conducted with chemically dependent youth at the Dr Fabian and Florence Ribeiro Treatment Centre based in Cullinan who were left with two weeks to complete their treatment before going back to their families. The perceptions and experiences of participants were recorded, documented, analysed and also confirmed through the relevant literature. The data were divided into themes, sub-themes and categories (where applicable).

The analysis of data from the semi-structured interviews resulted in **six themes**, namely:

- The addiction history of participants.
- Participants' self-perceptions: past, present and future.
- Family situation of participants: past and present.
- Perceptions, expectations and fears of participants about being reintegrated into their family systems.
- Support needs of participants when being reintegrated into their family systems.
- Experiences of participants during weekend leave.

Theme 1 focused on the addiction history of the participants and was further divided into the following sub-themes: (1) Substance of choice – types of substances abused by participants; participants' experiences at previous rehabilitation centres; participants' reasons for relapse, and participants' reasons and motivations for present admission to DFFRTC

The information pertaining to Theme 2: Participants' self-perceptions: past, present and future were presented under three sub-themes: Participants' perceptions about their old and new selves, and participants' perceptions about their future and future plans.

Under Theme 3, the family situation of the participants: past and present, the information shared by the participants was presented under the following sub-themes:

- The nature of the family's relationships with the participants: past and present
- Participants' past relationships with their fathers and mothers
- Participants' past relationships with their siblings and other family members
- Participants' perceptions about going back to their families

Under Theme 4, entitled: "Perceptions, expectations and fears of participants about being reintegrated into their family systems", the information shared by the participants was presented under the following sub-themes:

- Aspects that excite participants about going back to their families
- Participants' fears about being reunited with their families.
- The participants' perceptions about their respective families' expectations of the participants following their treatment
- Participants' expectations of their families and needs for assistance in relation to being reintegrated back into the family system
- Perceived challenges in being reunited with their families.

Theme 5 focused on the support needs of the participants directed to the DFFRTC and the social workers in respect of their reintegration with their families. The information related to this theme was presented under two sub-themes, namely: participants' support needs directed to the DFFRTC and social workers, and participants' perceptions of what will ease their integrating back into their families

A unique theme emerged focusing on the experiences of participants during weekend leave and the information emerging from this theme was presented under the following sub-themes:

- Persons with whom the participants spent their weekend leave and the activities they engaged in
- Temptations participants encountered during the weekend leave and participants' reaction

- Relapse during the weekend leave

The next chapter of the report will focus on a summary of the previous chapters, and conclusions arrived as a result of this research project while recommendations will be put forward on the basis of the conclusions.

CHAPTER 4

SUMMARY, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

In the previous chapters of this research report a description was provided of a research endeavour undertaken with the aim of exploring and describing the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre regarding reintegration into their family system.

In this last chapter of this research report, a brief summary of the previous chapters will be provided. The conclusions arrived at, with specific reference to Chapters 2 and 3, will follow these summaries and then recommendations will be made directed at policy, social work practice, the rehabilitation centre where the research was undertaken and an agenda for further and future research will be provided.

4.2 Summary of Chapter 1

In Chapter 1 of this research report the researcher introduced the research topic and provided a problem formulation and a justification and/or motivation for why there was a need for venturing on this research journey. Based on a literature search undertaken for the topic under investigation (for the outcome of the former see Chapter 1: Section 1.1), the researcher arrived at the conclusion that literature focusing specifically on the perceptions of chemically dependent youth in terms of support needs, expectations, and fears about reintegration into the family system after a rehabilitation programme is lacking and warrants investigation. As social worker at the Dr Fabian and Florence Ribeiro Treatment Centre, an in-patient treatment centre for chemically dependent clients/service users, in Cullinan in the Gauteng Province, she works on a daily basis with service users who present with chemically dependent problems. Service users are admitted to the centre for a period of three months. During the three-month period they go through a structured rehabilitation programme which is facilitated by a multi-disciplinary team. Each service user is assigned to a social worker for the said period and the latter is expected to render social work services through individual therapeutic sessions and group sessions. During this three-month period the service users are

allowed to go for three days of therapeutic leave if they are from Gauteng province and five days of therapeutic leave when they are from another province, when they have completed two months of their three-month programme. On their return from this period of leave, the researcher was informed about many family problems at home, such as: co-dependency, lack of trust, lack of support from family members and high expectations of family members about their recovery. All of the aforementioned complicate their integration back into the family and contribute to a lack of confidence and fears for relapse amongst the service users. The said problems and complaints shared with the researcher in her capacity as social worker, on more than one occasion, coupled with the lack of literature on the topic mentioned earlier, ignited the researcher's curiosity and motivated her to look deeper into the perceptions, expectations, fears of the chemically dependent youth about their reintegration back into the family system and their needs in this regard.

Following on the introduction and background to the study, the problem statement and motivation for this study, the researcher also in Chapter 1 formulated the research question to focus this research endeavour and stated a goal and objectives to structure the process of answering the formulated research question. The research approach, design and method proposed for this study also formed part of Chapter 1. The ethical considerations she proposed to observe during this research endeavour were also covered in the chapter.

4.3 Summary of Chapter 2

In Chapter 2 the researcher provided a description of the research methodology employed for this study. The qualitative research method was chosen and a description of how it was implemented was discussed. Data were collected by means of semi-structured interviews, analysed according to the steps for qualitative data analysis as proposed by Tesch (cited in Creswell, 2009:186) and trustworthiness was addressed through Guba's model (cited in Shenton, 2004: 64-73) as a way of validating the findings.

4.4 Conclusions and recommendations based on the research approach, design and method utilised

The researcher arrived at the conclusion that the qualitative research approach adopted for this study proved to be an effective means as it allowed her to gain an in-depth understanding of the participants' perceptions, expectations, fears, and needs and the meaning they attach to the event of returning home to their family systems after being in an in-patient rehabilitation centre for three months. Where a researcher aims to develop an in-depth understanding of a phenomenon under investigation and obtain an insider perspective the researcher wants to recommend to similar researchers that they employ a qualitative research approach. Furthermore, the explorative, descriptive and contextual research design employed in this research afforded the researcher the opportunity to explore and describe (from the context of chemically dependent youth who have been in an in-patient rehabilitation centre for three months) their perceptions, expectations, fears and support needs about going back home to their families. If a researcher wants to explore and describe a phenomenon contextually, then the researcher wants to recommend that such a researcher use an explorative, descriptive and contextual research design, based on her experience about the fittingness of such a design to meet the stated objectives set in this regard. The means employed for data collection (i.e. the semi-structured interviews) seemed to be a good fit as it enabled the researcher to obtain rich information about the participants' experiences of their families, their needs and expectations, and how they think their families can assist them to prevent relapse and to be reintegrated with them successfully. The researcher wants to propose the use of semi-structured interviews to researchers who aim to obtain rich information about the topic under investigation. The eight steps for how to analyse qualitatively generated data proposed by Tesch (cited in Creswell, 2009) assisted the researcher in a user-friendly manner to tackle the mammoth task of analysing the generated qualitative data. Based on her experience the researcher can recommend to novice researchers the use of these eight steps as it will aid them in a systematic manner to approach the task of analysing the data collected. The researcher arrived at the conclusion that Guba's model (cited in Krefting, 1991; Shenton, 2004) assisted her in her endeavours to enhance the trustworthiness of the findings, and recommends to any qualitative researchers who want to ensure the trustworthiness of their study and validation of the findings to employ the strategies inherent in this model.

4.5 Summary of and conclusion on Chapter 3

Chapter 3 covered the findings of this study. The findings were reported as themes, sub-themes and categories emerging from the process of data analysis. The emerged themes, sub-themes and categories were underscored by direct quotations from the interviews to give a clear description of the contents and to provide motivation for the findings.

The data from the semi-structured interviews were divided into five main themes and one unique theme with accompanying sub-themes and where applicable categories. In the ensuing discussions each of these themes will be presented in a summarising fashion and the conclusion arrived at on a particular theme will be presented.

Theme 1: The addiction history of participants

This theme was sub-divided into the following sub-themes:

- Substances of choice – types of substances abused by participants
- Participants' experiences of previous rehabilitation centres
- Participants' reasons for relapse
- Participants' reasons and motivations for present admission to DFFRTC

From the data collected, the researcher came to the conclusion that all the participants, with the exception of one, abused more than one chemical substance (see Table 3.1 and 3.3 in Chapter 3 of this report) (cf. South African Community Epidemiology Network on Drug Use, 2011:5).

With reference to the information shared by the participants about their previous experiences of rehabilitation centres, the researcher was informed that the participants had been to a variety of rehabilitation centres. Some went to private rehabilitation centres, others mentioned that they went to farm-like rehabilitation centres and some attended an outpatient rehabilitation centre. Some mentioned that they had attended a 35-day rehabilitation programme. From their accounts the researcher discovered that at some of these centres it was easy to smuggle substances, and one participant referred to the private rehabilitation centre as “a hotel”.

From the utterances made by the participants relating to the reasons for their relapse the researcher concluded that these reasons were mostly directed at other people and external circumstances and they were using defence mechanisms such as blame. The participants were blaming the environment, bad friends, relationship problems, having money and cravings as the reasons for their relapses. None of the participants took responsibility by admitting that it was a choice they had made.

The researcher arrived at the conclusion that the participants' reasons for their present admission to DFFRTC were due mainly to voluntary admission and admission through court intervention.

Theme 2: Participants' self-perceptions: past, present and future

The researcher came to the conclusion that some of the participants had negative self-perceptions and they perceived their significant others to view them in a negative light while they were abusing chemical substances (cf. Schäfer, 2011:140). With reference to the former they saw themselves as "failures", "destructive" and being the black sheep in their families.

The researcher discovered that following the treatment the participants developed self-belief that they had changed for the better and could not afford to go back as they see a better future without substances.

From the stories shared by the participants the researcher concluded that they, as result of the treatment, want their lives to get back on track once they leave the rehabilitation centre. To this effect some mentioned wanting to and going to a different environment, wanting to get a job or further their studies and start a new life.

Theme 3: Family situation of participants: past and present

The aim of this study was not to investigate family composition, and past and present relationships; however, the following did emerge from the interviews and was subsequently divided into four sub-themes which are as follows:

- Family composition of participants.

- The nature of the family relationships with the participants: past and present
- Participants' past relationships with their fathers and mothers
- Participants' past relationships with their siblings and other family members.

When looking at the participants' family composition the researcher came to the conclusion that half of the participants were from non-intact families as some of their parents were divorced, and some had lost a parent through death (cf. Paxton et al., 2007:594). Furthermore, some made mention of the fact that they were staying with extended family members. In terms of having siblings, some of the participants had siblings, but others were the only child in their families.

In terms of relationships with their respective families and extended families the researcher arrived at the following conclusions:

- The participants had negative past relationships prior to rehabilitation with their respective families (cf. Bezuidenhout, 2004:127; Webber, 2003:233-236) but this had in general changed considerably during the time the participants were in the rehabilitation centre.
- While more participants (eight) had strained relationships with their fathers, more of the participants had good relationships with their mothers before they went for treatment. These relationships were mostly still intact during the treatment period. Five participants shared that their relationships with their mothers were not good, but three of them asserted that the relationships with their mothers had improved, while one participant's mother had passed away. Only one participant's relationship with her mother was strained.
- Only one participant described his past relationships with his siblings as good. He still maintained the relationships while he was in DFFRTC. Five participants had problematic relationships with their siblings before they were admitted to DFFRTC. Two of these indicated that the relationships had improved while the other three did not really comment on any change in the relationships. Five of the participants mentioned relationships with other important family members in their lives, for example two mentioned that they had good relationships with their grandparents and always got good advice from them, others mentioned family members like uncles and

aunts that did not trust them as they lied and stole from them and they did not have a good relationship with them.

Theme 4: Perceptions, expectations and fears of participants about being reintegrated into their family systems

This theme was divided into sub-themes which will be discussed in a summarising and concluding fashion below.

Sub-theme: Participants' perceptions about going back to their families

The researcher came to the conclusion that the perceptions of participants about going back to their respective families varied from being positive to negative. The reasons for their negative perceptions about going back to their families were due to the fact that their families criticise them a lot, treat them like addicts, and they do not trust them. Furthermore, some of their family members were abusing substances (cf. Henry et al., 2003:44) and this would make it difficult for them to stay clean as they perceived their family members' addiction as a temptation that could lead to their relapse.

The six participants who had positive perceptions about returning to their families described their families as "nice people". They felt positive about their families and were looking forward to joining them again at home. Some even mentioned that the family was looking forward to seeing them. Moreover, some of the participants claimed that their families had already organised employment, a place to stay and financial assistance.

Sub-theme: Aspects that excite participants about going back to their families

The researcher came to the conclusion that various aspects excited the participants about being reunited with their families. In this regard she discovered the following:

- The participants were excited about going back to their families as they wanted to show them that they had changed for the better and that they are not bad people but substances made them to do bad things, such as stealing from their families. They were proud of their achievement at the DFFRTC as they were going back to their families in a sober condition and were looking forward to showing this to the outside world.

- Eight of the participants commented that they were looking forward to seeing their families after three months in rehabilitation. They mentioned that they just want to spend time with them and tell them how they felt about them.
- The participants were excited and looking forward to starting a new life upon leaving the rehabilitation centre and shared feelings of happiness and freedom as they would be able to enjoy things like driving and shopping, activities that they could not engage in while in rehabilitation.

Sub-theme: Participants' fears about being reunited with their families

The researcher came to the conclusion that the fears of the participants about being reunited with their families can be attributed to both internal and external sources:

- Four participants frankly shared their fear of relapsing as they do not trust themselves; some of these participants mentioned that they were scared of triggers such as alcohol, family members who are abusing a substance (cf. Witkiewitz & Bowen 2010:362; Hammerbacher & Lyvers, 2006:39) and bad friends (cf. Park et al., 2009: 50; Van der Westhuizen, 2010:138).
- Participants feared and/or were worried that their families would not accept that they have changed as they have disappointed them in the past (more than once) by stealing, deceiving and being untrustworthy to them. Family members will test them by setting traps to see if they have really changed, for example: by leaving valuable stuff in the open to see if they can be trusted. Participants believe that this has the potential to destroy the relationships as they expect their families to just believe in and trust them.
- Some of the participants shared that they were scared of going back to their old environments where friends would either react negatively, or try to tempt them to use substances again.

Sub-theme: The families' expectations seen from the participants' perceptions following their treatment

While no specific question was asked about what the participants' families would be expecting of them, some of the participants provided their perceptions about what they thought their families would expect of them when they re-joined their families. The participants held the perception that they would have to regain their family's trust by proving to them that they have recovered from their addiction. They indicated that this can be achieved by refraining from using substances and stealing from them. Furthermore, they held the perception and indicated that they would like to ask for forgiveness from their families for all the bad things they have done.

The participants' perceptions were that their families would expect of them to make good choices about their future according to their family values. They would be expected to go to church; to school, and refrain from substances and bad friends.

Sub-theme: Participants' expectations of their families and needs for assistance in relation to being reintegrated back into the family system

From the accounts of the participants the researcher arrived at the conclusion that the former harboured various expectations of their families after being reunited with them. These expectations are summarised below:

- The participants expect and need their respective family members to show them that they trust them by not referring back to the past and by acknowledging the achievement they reached at the rehabilitation centre. They also expect their families to refrain from labelling and to treat them like normal people as they have changed.
- The participants expect and need their families to give them love by showing concern for and nurturing them, and to accept them the way they are in order to assist them to regain their self-confidence lost as a result of abusing substances, this being one of the contributing factors to their starting to abuse substances. They also expect their families to support them by being there for them all the time and to give them encouragement and motivation.

- The participants expressed the need to bond with their families and spend quality time with them in order to re-build the relationships broken while they were abusing substances. They would like to communicate more with them and spend more time with them and do things together such as going to church.
- The participants expect and need practical help. This varied from financial assistance, help in finding jobs, going back to school and assistance with looking after their children until they can find a job and also informing other family members that the participant is now a changed person.
- Participants expect and need the family to become educated about addiction in order to understand them better.
- Participants indicated that they would like their families to attend aftercare services with them in order to support and understand them better.

Sub-theme: Perceived challenges in being reunited with your family

With reference to this sub-theme the researcher discovered that what the participants perceived as challenges in being reunited with their families were: their old friends, how to fill free-time, and the challenges related to being dependent on the family while trying to move towards the destination of independence.

Theme 5: Support needs of participants directed to the DFFRTC and social workers about being reintegrated into their family systems

With reference to the participants' support needs from DFFRTC and social workers the researcher came to the conclusion that the need of support directed to the institution and the social workers was both internally and externally focused. With reference to the support needs internally focused, in terms of how the participants want to be supported whilst at the rehabilitation centre; some participants expressed the need for individual sessions apart from group sessions. One of the participants felt the need to include the family in individual sessions and another felt that they needed personal support from social workers such as encouragement, comfort and hope that they would be fine. Some of the participants suggested that the rehabilitation centre should develop more activities. They felt that there was not enough to do and that they were bored during their free times. Participants indicated

that they would like their families to be part of their recovery process while at DFFRTC and also indicated that they would like their families to be given feedback on their progress.

As far as the externally focused support needs were concerned some the participants proposed that a proper aftercare programme should be introduced into the communities in collaboration with DFFRTC.

Sub-theme: Participants' perceptions on what will ease their integrating back into their families

Apart from the support of the family, the attitude of trust displayed towards the participants by the family and the family being educated on the topic of substance abuse and aftercare services (referred to above), the researcher discovered that the following aspects will in a complementary manner ease their integration back into their families:

- Some of the participants felt that they were responsible for reintegration with their families by staying positive, focused and sober.
- One participant indicated a need for a letter to state that he had attended school while he was at the rehabilitation centre.

Unique theme: The experiences of participants during weekend leave

This unique theme emerged from the responses of the participants who spoke about their weekend leave four weeks prior to their release from the rehabilitation centre.

The researcher discovered that -

- Most of the participants went home to their families for their weekend leave while one only went out for a day and another participant spent the weekend at a friend's place.
- Participants become acutely aware of the temptations of using substance which are "out there" and the weekend leave assisted them in realising the challenges that they are going to face after their rehabilitation. They mentioned things like triggers and peer pressure.
- One participant relapsed during her weekend leave as her family did not have faith in her and this triggered her to use with her sister as she is also addicted to drugs (cf. Witkiewitz and Bowen, 2010: 362).

Before the recommendations (based on the conclusions) are presented, the limitations of the study will be presented in the next section of this chapter.

4.6 Limitations of the study

The researcher did not experience any limitation regarding the implementation of the research methodology that was chosen for this study. However, limitations were experienced in this research for the following reasons:

- There were more males than females in the study so that there was inequality in the information collected as females were less represented.
- The study was only conducted at one treatment centre due to a lack of resources, as a result limiting the acquisition of contrasting or more information from other rehabilitation centres.
- There were more coloureds and black participants in the study, and only two whites and no Indians participated in the study, as a result limiting information that would have been collected from other race groups in South Africa.
- The participants in the study are from a Government rehabilitation centre where services are offered free of charge which could imply that they are from families who cannot afford to pay for private rehabilitation centres. Therefore, this could mean that the study failed to offer the perceptions, expectations, fears and support needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family system from different economic backgrounds.

4.7 Recommendations

Based on the research findings presented in Chapter 3 of this report and the corresponding conclusion and discoveries made by the researcher and presented under section 4.2.3 of this chapter, the researcher wishes to put forward some general recommendations pertaining to the phenomenon of chemical substance abuse, as well as recommendations directed to the management of the DFFRTC and the social workers rendering social work services at this centre. The researcher also proposes an agenda for further and future research.

4.7.1 General recommendations pertaining to the phenomenon of chemical substance abuse

One of the findings of this research was that participants felt that going back to their environment poses a threat to their recovery because substances are readily accessible. Furthermore, drug abuse is a serious problem that is affecting their well-being and destroying the future of the youth in South Africa (cf. Jackson et al, 2007:322; Dube, 2007:28; Schäfer, 2011:35). It is therefore recommended that community members and community organisations (i.e. Non-Governmental Organisations (NGOs), Community Based Organisations (CBOs) and Faith Based Organisations (FBOs)) should play a vital role in partnership with the government in order to overcome this complex and serious problem of drug abuse. Community members, organisations and the government sector need to develop and launch chemical substance abuse prevention and awareness programmes through various media, talks, community gatherings and meetings in all communities. The latter need to be informed about the risk substances pose to our youth and communities in South Africa.

Families are the pillars of society and therefore every family has the responsibility to boost their children's morale and esteem without the child having to rely on external opinions and guidance which could be detrimental to their well-being and might lead them to use substances and engage in negative or dangerous behaviour (cf. Haines & Case, 2005:169). In order to help the youth to acquire skills to resist temptations and to deal with the problem of substance abuse, families need to take up ownership of the responsibility of rearing their children and equipping them with the right morals and values of society in order to become useful members of the society. Moreover, parents should take responsibility for monitoring and countering substance abuse in their children (cf. Reddy, 2009:91). Families need to be empowered through talks, attending parenting skills training, workshops and group meetings arranged by non-governmental organisations (NGOs), faith-based organisations (FBOs), community-based organisations (CBOs) and government structures which will equip them with skills, not only to deal with problems such as substance abuse in a reactive manner, but also in a preventative manner.

According to the Green Paper on Families (South Africa, 2011: 15), South Africa has no policy framework that specifically addressed the family in South Africa, therefore a policy focusing on families needs to be developed by the government departments in partnership

with non-governmental organisations (NGOs), faith-based organisations (FBOs), community-based organisations (CBOs) and the business sector in South Africa in order to strengthen South African families to deal with the serious and complex problem of substance abuse that is facing South African families and increasing at an alarming rate (cf. National Department of Social Development 2011:2-4). This policy can be implemented by means of programmes that will focus on strengthening families, intervention programmes for families who have substance abuse problems and parenting skills programmes.

4.7.2 Recommendations directed to the management of the DFFRTC and the social workers rendering social work services at this centre¹⁰

Based on the findings and the conclusions arrived at the following recommendations are directed to the management of the DFFRTC and the social workers rendering social work services at this centre:

- **The provision of individual sessions:** Although there are group sessions offered in the DFFRTC treatment centre, the majority of the participants in this study emphasised the need for individual sessions in order to deal with issues that are not possible to deal with in a group setting. As much as service users/clients in rehabilitation centres are admitted with a common problem of substance abuse they still need to be treated as individuals who have individual needs that might not be addressed in a group setting. Therefore, it is recommended that individual sessions form part of social work interventions at this centre as it is where clients/service users will be able to deal with their personal problems in a safe and private environment where their needs will be dealt with personally rather tackled in a group setting where others might be shy about communicating their problems in the fear that everyone will get to know about their problems.
- **The provision of family therapy:** In order to deal with the problem of drug abuse systemically, it is recommended that counselling should not be offered only to the person experiencing a problem, but also to his/her family members because looking at

¹⁰ Although these recommendations are directly related to the DFFRTC and the social workers rendering social work services to the service users at this centre, these recommendations may also be applicable (although the intention of qualitative research is not to generalise findings) to the management and social workers at other centres rendering services to chemically dependent service users.

the phenomenon of substance abuse from a systemic perspective it becomes clear that when one subsystem (i.e. a youth) abuses chemical substances it has an effect on the whole system (i.e. the family) (cf. Jackson et al., 2007:322) as explained in Chapter 3 of this report. Furthermore, this study found that some of the participant's family members were abusing substance, and this might have a negative effect on the recovery of the participants, therefore it is recommended that family therapy should form the basis of treating substance abuse. It is recommended that the DFFRTC investigate the possibility of how to incorporate family therapy as part of their treatment regime; that they look at how this mode of treatment can be accommodated as part of the in-patient treatment and/or how it can be outsourced and/or offered on an out-patient basis.

It is further recommended that the following topics need to be covered during the family therapy sessions: Trust and relationship building between the patient and the family¹¹, educating the family about the family member's addiction, the impact of the addiction on the family and how to support the family upon release from the treatment centre. The family therapy might also uncover other members of the family's chemical addiction and triggers that might cause the family member to relapse.

- **The provision of aftercare services:** Based on one of the findings it is recommended that social workers need to provide aftercare services to substance abusing clients who leave a rehabilitation centre in order to sustain sobriety and prevent relapse. Once again the management of the **DFFRTC** should investigate how aftercare services can be offered at the treatment centre or on an out-patient basis and how to adjust their policies to accommodate this and to develop partnerships in the community to assist with rendering of aftercare services to services users who have completed their in-patient rehabilitation at the centre. Furthermore, it is recommended that these aftercare services should include the families of the patients not only to ensure that they understand addiction, triggers and the possibility of relapsing, but also to provide a protective buffer of support to the addicted family member on the way to recovery.

¹¹ The participants' perceptions of lack of trust and poor relationships were a central theme interspersed throughout the participants' stories shared with the researcher.

- **The provision of more extramural activities:** It is recommended that the management and members of the multi-disciplinary team investigate the possibility of introducing more extramural activities at **DFRTC** in order to curb boredom and ensure that recovering addicts learn more skills. This will ensure that recovering addicts have meaningful post-rehabilitation lives which will inevitably minimise the prospects of relapse.

4.7.3 Recommendations for further and future research

It is recommended that:

- This research project be replicated with a larger sample which will include more female participants and participants from the Indian and White segments of the population and also more rehabilitation centres in South Africa in order to provide more generalisable results.
- A research project be undertaken to explore and describe the perceptions, expectations, fears and support needs of families in relation to the reintegration of a chemically dependent youth back into the family system.
- A research project be undertaken to explore and describe the experiences and challenges of non-abusing siblings living with substance abusing siblings

4.8 Conclusion

In this research report an account was provided of the perceptions, expectations, fears, and needs of youth addicted to chemical substances in relation to being integrated with their family systems after being in an in-patient rehabilitation centre for a period of three months. This research endeavour did not only make information available on the aspects previously mentioned, but also made information available which will afford the **DFRTC** and other similar treatment centres an opportunity to revisit their services and treatment modes offered and the limitations hitherto experienced. Through this research endeavour the researcher also put forward an agenda for further and future research to add to the body of knowledge related

to the topic of chemical substance abuse, the client-systems involved and the social work services and service delivery to the client-system group concerned.

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ADDENDUM A

**A LETTER REQUESTING INDIVIDUALS' PARTICIPATION IN A RESEARCH STUDY**

11 January 2011

Dear _____

I, Jeaneth Linki Matsimbi, the undersigned, am a social worker in service of the Dr Fabian and Florence Ribeiro Treatment Centre at Cullinan, and also a part-time master's student in the Department of Social Work at the University of South Africa. In fulfilment of requirements for the master's degree, I have to undertake a research project and have consequently decided to focus on the following research topic: The perceptions, expectations, fears and support needs of chemically dependent youth at a rehabilitation centre about being reintegrated into their family systems.

In view of the fact that you are well-informed about the topic, I hereby approach you with the request to participate in the study. For you to decide whether or not to participate in this research project, I am going to give you information that will help you to understand the study (i.e. what the aims of the study are and why there is a need for this particular study). Furthermore, you will be informed about what your involvement in this study will entail (i.e. what you will be asked/or what you will be requested to do during the study, the risks and

benefits involved by participating in this research project, and your rights as a participant in this study).

This research project originated as a result of the increase rate of substance abuse in South Africa and the fact that this problem is especially rampant among the young people of South Africa. As a Social Worker who is working in a rehabilitation Centre for substance abuse I have realised that the service users who are admitted in the Centre are experiencing family problems during their discharge from the Centre after they complete their treatment programme. These family problems start showing when they go for their therapeutic leave after their eight weeks in the centre. Upon their return from leave they present with problems and challenges such as feeling that their family members do not trust them, lack of support from family members and high expectations from family members about their recovery which complicates their integration back into the family and this leads to a lack of confidence and fears for relapse amongst the service users. These presenting complaints and problems have in more ways than one been repeated in most of the cases and therefore challenge one to want to look deeper into the perceptions, expectations, fears of the chemically dependent youth about their reintegration back into the family system and their support needs in this regard and the aim of this research project is to develop an in-depth understanding of the perceptions, expectations, fears and support needs of the youth after an in-patient treatment programme in terms of being reunited with their families.

The information gathered from this study will help with getting more information and deeper understanding of the experiences, fears and needs of chemically addicted youth after a rehabilitation programme. This study will also contribute towards a holistic in-patient treatment programme for the youth and assist social workers in identifying aftercare needs.

Should you agree to participate, you would be requested to participate in one face-to-face interview that will be conducted at the Dr Fabian and Florence Ribeiro Treatment Centre in the Social Worker's offices from 10:00 to 11:00. It is estimated that the interview will last approximately one hour. During the interviews the following questions will be directed to you:

- ❖ How old are you?
- ❖ What is your Gender?

- ❖ Race?
- ❖ Where do you stay?
- ❖ Employment status?
- ❖ First admission or readmission?
- ❖ Type of substance used?
- ❖ How can your family assist you in relation to your integration back into the family system?

- ❖ What are your perceptions about going back to your family?
- ❖ What are your expectations of your family members after completing the treatment?
- ❖ What are your fears about going back to your family?
- ❖ What excites you about going back to your family (being reintegrated)?
- ❖ What do you perceive to be your challenges when you are reunited with your family?
- ❖ What do you need (or your needs) in order to be reintegrated with your family?
- ❖ How can the rehabilitation centre support you in respect of successful integration with your family?
- ❖ How can the Centre and Social Workers assist you in terms of reintegration with your family?
- ❖ What do you think will make reintegration with family easier for you?

With your permission, the interview will be audiotaped. The recorded interviews will be transcribed word-for-word. Your responses to the interview (both the taped and transcribed versions) will be kept strictly confidential. The audiotape(s) will be coded to disguise any identifying information. The tapes will be stored in a locked office at the Dr Fabian and Florence Ribeiro Treatment Centre in the Social Work offices room number 11 and only I will have access to them. The transcripts (without any identifying information) will be made available to my research supervisor(s), a translator (if they need to be translated into English), and an independent coder for the sole purpose of assisting and guiding me with this research undertaking. My research supervisor(s), the translator and the independent coder will each sign an undertaking to treat the information shared by you in a confidential manner. The audiotapes and the transcripts of the interviews will be destroyed upon the completion of the study. Identifying information will be deleted or disguised in any subsequent publication and/or presentation of the research findings.

Please note that participation in the research is completely voluntary. You are not obliged to take part in the research. Your decision to participate, or not to participate, will not affect you in any way now or in the future and you will incur no penalty and/or loss to which you may otherwise be entitled. Should you agree to participate and sign the information and informed consent document herewith, as proof of your willingness to participate, please note that you are not signing your rights away.

If you agree to take part, you have the right to change your mind at any time during the study. You are free to withdraw this consent and discontinue participation without any loss of benefits. However, if you do withdraw from the study, you would be requested to grant me an opportunity to engage in informal discussion with you so that the research partnership that was established can be terminated in an orderly manner.

As the researcher, I also have the right to dismiss you from the study without regard to your consent if you fail to follow the instructions or if the information you have to divulge is emotionally sensitive and upsets you to such an extent that it hinders you from functioning physically and emotionally in a proper manner. Furthermore, if participating in the study at any time jeopardises your safety in any way, you will be dismissed.

Should I conclude that the information you have shared left you feeling emotionally upset, or perturbed, I am obliged to refer you to a counsellor for debriefing or counselling (should you agree).

You have the right to ask questions concerning the study at any time. Should you have any questions or concerns about the study, contact these numbers 0834523846/012 5491479.

Please note that this study has been approved by the Research and Ethics Committee of the Department of Social Work at Unisa. Without the approval of this committee, the study cannot be conducted. Should you have any questions and queries not sufficiently addressed by me as the researcher, you are more than welcome to contact the Chairperson of the Research and Ethics Committee of the Department of Social Work at Unisa. His contact details are as follows: Prof AH (Nicky) Alpaslan, telephone number: 012 429 6739, or email alpasah@unisa.ac.za.

If, after you have consulted the researcher and the Research and Ethics Committee in the Department of Social Work at Unisa, their answers have not satisfied you, you might direct your question/concerns/queries to the Chairperson, Human Ethics Committee, College of Human Sciences, PO Box 392, Unisa, 0003.

Based upon all the information provided to you above, and being aware of your rights, you are asked to give your written consent should you want to participate in this research study by signing and dating the information and consent form provided herewith and initialling each section to indicate that you understand and agree to the conditions.

Thank you for your participation.

Kind regards

Signature of researcher

Contact details: (O) 0834523846/0835662221

(Fax) 0866918150

(Email) Jeaneth.matsimbi@gauteng.gov.za

ADDENDUM B

INFORMED CONSENT DOCUMENT

TITLE OF THE RESEARCH PROJECT:

THE PERCEPTIONS, EXPECTATIONS, FEARS AND NEEDS OF CHEMICALLY DEPENDENT YOUTH AT A REHABILITATION CENTRE ABOUT BEING REINTEGRATED INTO THEIR FAMILY SYSTEM.

REFERENCE NUMBER: _____

PRINCIPAL INVESTIGATOR/RESEARCHER: Jeaneth Matsimbi

ADDRESS: 102 Ribbon Street

Orchards

0118

CONTACT TELEPHONE NUMBER: 0834523846/0835662221

<p>DECLARATION BY OR ON BEHALF OF THE PARTICIPANT:</p> <p>I, THE UNDERSIGNED, _____ (name),</p> <p>[ID No: _____] the participant or in my capacity as _____ of the participant</p> <p>[ID No _____] of _____</p> <p>_____</p> <p>_____ (address)</p> <p>A. HEREBY CONFIRM AS FOLLOWS:</p>	<p><u>Initial</u></p>
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<p>1. I/the participant was invited to participate in the above research project which is being undertaken by Jeaneth Matsimbi of the Department of Social Work in the School of Social Science and Humanities at the University of South Africa, Pretoria, South Africa.</p>	
<p>2. The following aspects have been explained to me/the participant:</p> <p>2.1 Aim: The researcher is studying</p> <p>To gain an in-depth understanding of chemically dependent youth at a rehabilitation centre's perceptions, expectations, fears, and needs about reintegration into the family system</p> <p>The information will be used to</p> <p>Get more information and deeper understanding of the experiences, fears and support needs of chemically addicted youth after a rehabilitation programme. This study will also contribute towards holistic in-patient treatment programmes for the youth and to assist social workers in identifying aftercare needs.</p>	<p><u>Initial</u></p>
<p>2.2 I understand that</p> <ul style="list-style-type: none"> ❖ Participation in this study is voluntary and I have the right to change my mind at any time during the study. ❖ I am free to withdraw this consent and discontinue participation without any loss of benefits. ❖ The researcher has the right to dismiss me from the study without regard to my consent if I fail to follow the instructions or if the information I have to divulge is emotionally sensitive and upsets me to such an extent that it hinders me from functioning physically and emotionally in a proper manner. Furthermore, if participating in the study at any time jeopardises my safety 	<p><u>Initial</u></p>

<p>in any way, I will be dismissed.</p>	
<p>2.3 Risks: The research topic might induce sensitive emotions</p>	<p><u>Initial</u></p>
<p>Possible benefits: As a result of my participation in this study</p> <ul style="list-style-type: none"> ❖ This study will assist in developing holistic in-patient treatment programmes for the youth ❖ To assist social workers in identifying aftercare needs. 	<p><u>Initial</u></p>
<p>Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators/researchers.</p>	<p><u>Initial</u></p>
<p>Access to findings: Any new information/benefit that develops during the course of the study will be shared with me.</p>	<p><u>Initial</u></p>
<p>Voluntary participation/refusal/discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect me now or in the future.</p>	<p><u>Initial</u></p>
<p>3. The information above was explained to me by Jeaneth Matsimbi in Afrikaans/English/Sotho/Tsonga/Zulu/other_____ (indicate other language) and I am in command of this language/it was translated to me satisfactorily by _____ (name of the translator). I was given the opportunity to ask questions and all these questions were answered satisfactorily.</p>	<p><u>Initial</u></p>
<p>4. No pressure was exerted on me to consent to participate and I understand that I may withdraw at any stage from the study without any penalty.</p>	<p><u>Initial</u></p>
<p>5. Participation in this study will not result in any additional cost to me.</p>	<p><u>Initial</u></p>

B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE PROJECT.

Signed/confirmed at _____ on _____ 20__

Signature or right thumbprint of participant

Signature of witness

ADDENDUM C

IMPORTANT MESSAGE TO PARTICIPANT

Dear Participant

Thank you for your participation in this study. Should at any time during the study

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur:
becoming emotional after the interview and needing counselling, kindly contact Jeaneth Matsimbi at telephone number [0834523846]

ADDENDUM D

LETTER TO REQUEST PERMISSION TO DO RESEARCH

SEE ADDENDUM D ON THE FOLLOWING PAGES

ADDENDUM E

LETTER GRANTING PERMISSION TO DO RESEARCH

SEE THE NEXT PAGE