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Sub Study of 83/2017 - Experience of Family Support in the Recovery of Individuals Addicted to Psychoactive Substances

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Declaration

I, Candice Wepener (u13257952 / 9009280201080) declare that "Sub Study of 83/2017 – Experience of Family Support in the Recovery of Individuals Addicted to Psychoactive Substances" is my own work. I have acknowledged external sources and quotations appropriately and completely.

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Candice Wepener **26 June 2019**

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Abstract

Substance abuse and dependence are globally contested issues. In a volatile space, the field is undergoing major changes in terms of decriminalisation and reduction of harm efforts in numerous countries. Despite continued efforts to minimise or even eradicate substance use and abuse, recovery programmes still lack sustainability. Relapse is still common, and there is little in the way of literature explaining how some individuals manage successful sustained recovery. Although the field is undergoing many changes, it appears obvious that society still lacks adequate research and information to guide and motivate sustainable recovery.

Family systems are generally experienced as a person's primary system, and it may be assumed that many people become dependent on their family or family members for varying degrees of support. Systems theory underpinned this qualitative case study, comprising multiple cases, in order to explore the experience of individuals who expressed an interest in their own recovery and, more specifically, to discover whether they viewed family support as an assistive factor in this decision.

The study found that although family support did not motivate recovery, it was nevertheless an important factor in continued efforts toward recovery once the individual had made their own decision to commence a recovery programme.

Keywords: family support; qualitative research; recovery; substance dependence; systems theory

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Chapter 1: Introduction

1.1 Introduction

The first chapter of this research paper aims to contextualise the study entitled *Sub study of 83/2017 – Experience of family support in the recovery of individuals addicted to psychoactive substances*. It is important first to understand the need for this study, which is explained further in Chapters 2 and 3. The contextualisation of the study, in terms of how and where it was conducted, also explains who the participants are and why the study was conducted as it was. The research problem, the motivation for the study, the aims and objectives and the research process are discussed. These topics explain why the study was undertaken and why it was necessary. Finally, a full overview of the chapters that follow is provided.

"Though no one can go back and make a brand-new start, anyone can start from now and make a brand-new ending" (Sherman, 1982).

1.2 Contextualisation of the Study

Research findings show that substance abuse and addiction are worldwide problems (Central Drug Authority of South Africa, 2012), leaving the individuals concerned, as well as those around them, with psychological scars similar to those of general trauma (Sussman & Ames, 2001). Globally, countries such as Portugal, Norway, Australia and, very recently, South Africa are shifting toward the decriminalisation, albeit unofficial for the most part, of psychoactive substances (Eastwood & Rosmarin, 2012). Like the move towards decriminalisation, the reduction of harm of drug use, particularly for – but not limited to – people who inject drugs (PWID), started as a movement to eradicate HIV by 2030 (UNAIDS, 2014). Organisations such as OUT (n.d.) have initiated projects throughout South Africa to distribute clean needles and other materials for the safe use of drugs. OUT provides various health services and creates awareness in the gay, lesbian and transgender communities of

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Pretoria, reporting that they are reaching PWID and other drug users in order to reduce the harm associated with their habit. OUT has initiated the HARMless project, which is their initiative to reduce the harm of substance use in this targeted community. Unanticipated results reported by OUT (n.d.) and The Joint United Nations Programme on HIV/AIDS (UNAIDS) (2014) indicate that substance-dependent individuals are also being educated about the dangers of drugs and the associated lifestyle impact. Moreover, PWID and other substance users can go to a centre (OUT, n.d.) without being judged, where they are able to talk about their challenges with a listening ear and, in the process, receive educational information from former addicts and qualified healthcare and counselling professionals. Most feel that these are places where they are truly treated as people rather than addicts. It has been seen that, in a supportive and educational environment, some of these individuals do acknowledge the dangers of their habits and express interest in "kicking the habit", so to speak, even though it is a lengthy process (Eastwood & Rosmarin, 2012). This emphasises the importance of finding out what impact a supportive family may have had on individuals' recovery from addiction. Family members tend to focus on recovery programmes and half-way houses as treatment and as a result the substance-dependant individual may feel alienated, labelled and judged rather than supported (Centre for Substance Abuse Treatment, 2006).

The most recent World Drug Report explains that science-based rehabilitation programmes service fewer than one in six people with a substance disorder (United Nations Office on Drugs and Crime, 2017). Programmes that attempt to decriminalise and reduce harm are assisting by reaching greater numbers than that. Apart from the non-science-based programmes that are being launched to reach these individuals, there is also a shift towards families and informal helpers supporting addicts, and an expectation that this will occur (Centre for Substance Abuse Treatment, 2006). This could be because science-based programmes remain out of reach for many, particularly those in rural areas or informal settlements. There is an ongoing lack of access to basic and mental healthcare (Mayosi & Benatar, 2014). The responsibility for supporting people with substance disorders, therefore, appears to shift to the immediate family and communities (Centre for Substance Abuse Treatment, 2006). South African families already face a multitude of stressors, including poverty, unemployment, lack of education, the problem of single

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breadwinners for multiple families, and lack of infrastructure (Mayosi & Benatar, 2014). In the face of these environmental and societal challenges, the responsibility for caring for a substance dependent individual can be a trying one. Many people who deal with a substance dependent individual experience frustration and a lack of trust, especially if rehabilitation attempts are unsuccessful (Mayosi & Benatar, 2014).

An extensive review of recent literature suggests that, although there is widespread research regarding the detail of addiction or dependency, not much has been said about the success rate, or possible success rate, of recovery (Addiction Drug Alcohol Statistics South Africa, 2012). Furthermore, the experience of a recovering substance user is a tumultuous period in which it is necessary to avoid old acquaintances, fellow users, familiar places and places in which ingestion had previous been inevitable (Arria & McLellan, 2012). Meyer, Moore and Viljoen (2012) indicate that there is a need to move towards a quality system of substance rehabilitation, rather than attempting to move as many people through the system as possible. They argue that identifying factors that contribute to success in ongoing recovery may allow such factors to be utilised in future recovery programmes, thereby ensuring continued abstinence. The Central Drug Authority of South Africa (2012) emphasises the importance of ongoing recovery outside rehabilitation establishments; however, little is said about how to achieve this.

It has been established that it is essential for individuals addicted to psychoactive substances to feel understood and safe, and supported in their immediate surroundings (Stewart, 2010). Stewart's (2010) point about safe surroundings during recovery echoes the characteristics of centres that OUT has established in three major South African cities: Cape Town, Durban and Pretoria (OUT, n.d.). "Immediate surroundings" include family support systems, in an adaptive household, that should provide for the needs of the recovering addict. It must, however, be noted that families are not always a source of comfort or refuge, as some families are and remain maladaptive (Strong, De Vault & Cohen, 2008). Compton (2005) explains that social support varies from one individual to another. It is also said that "social support" is a broad term enveloping family, friends, colleagues and acquaintances (Strong et al., 2008). For the purpose of the study, "family support" is viewed in the same light as "social support". This explanation of family support may therefore be equated to the support received from other social connections. This includes informal help, such as empathic

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listening by family members, and relevant financial or other material support. It is no secret that recovery from substance addiction is a difficult road and frequently a life-long struggle for addicts (Shinebourne & Smith, 2011).

As Botticelli (2016) points out:

> All of us know someone who has an addiction, and all of us can do our part to change how we view people with addiction in the United States. So, when you see someone with an addiction, don't think of a drunk or a junkie or an addict or an abuser – see a person; offer them help; give them kindness and compassion. And together we can be part of a growing movement in the United States to change how we view people with addiction. (09:48)

The study aimed to find out whether participants experienced family support as a helping factor in their endeavour to recover from their dependence on psychoactive substances. The participants in the study had expressed a commitment to overcoming their addiction by participating in the Community Oriented Substance Use Project (COSUP), an initiative run by the Department of Family Medicine at the University of Pretoria (UP). COSUP aims to promote the reduction of harm and the decriminalisation of substance use in order to educate, raise awareness and contribute to the World Health Organisation's (WHO) goal to eliminate HIV and AIDs by 2030. Collaboration between myself and COSUP seemed like a natural step, as the project was well established in the Mamelodi community, servicing people who fit the study's inclusion criteria. The clinical associates (CAs) and social workers who were reaching these individuals were able to inform them of the study, at which point they could decide whether they wanted to participate or not. It was up to them to contact me in order to be interviewed.

The qualitative interviews were used as a tool to gain insight into the subjective experiences of these individuals and ultimately to find out whether they felt that support from their families was enabling them to make the transition from addict to recovering addict. The Reduction of Harm Coalition (2012) explains that the principle of reducing harm is to minimise the negative effects of substance use, such as alienation from societal ties, the spread of disease and unsuccessful recovery tactics. The aims of COSUP and other reduction of harm projects align directly with the aim of this study, which is to find out what, in the experience of an addict, aids their recovery. The study, however, focused

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specifically on whether direct family support had an influence on the ongoing recovery of individuals addicted to psychoactive substances. Exploring the participants' views of what a functional family system is, and identifying who they viewed as family members, became integral to the study. The question arose of who participants identified with and found to be supportive in various ways. As all individuals belong to different systems, I wanted to know if a family as a system may be seen as a contributing factor to recovery from addiction. More specifically, I wanted to find out whether a supportive family was an identifiable factor or not.

As mentioned above, the study was based in Pretoria, and participants were more specifically from Mamelodi. Because participants were able to contact me directly and so as not to inconvenience them, I travelled to them to conduct the face-to-face interviews. Interviews were conducted in accordance with an ethically approved interview schedule. At certain points the participants may have strayed from the questions, as can be expected from qualitative data. Interviews varied in length between 15 and 40 minutes, and all the participants' reflections and subjective experiences were accepted as factual data and contributions to the findings.

The reason for conducting the study was the lack of information revealed by the literature study about how persons battling addiction have managed to commit to making a change in their lives after the use and abuse of, and addiction to, psychoactive substances. This study aspired to explore one possible factor in the ongoing recovery from addiction. By no means does this study aim to provide a general answer to the research question: "What is the substance abuser's experience of the role of family support in the recovery of a person who is addicted to psychoactive substances?" The study does, however, aspire to identify whether family support is one of the helping factors in the experience of this sample of substance dependent individuals.

1.3 Research Problem

The research intended to explore the experience of substance dependant individuals who expressed an interest in their own recovery and, more specifically, to discover whether they viewed family support as an assistive factor in this decision.

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1.4 Motivation for Study

According to the 2017 World Drug report, approximately five percent of the global adult population used a substance in 2015. Point six percent of the drug using population were identified as suffering from some form of drug use disorder, which equates to a staggering 29.5 million drug users, as estimated by the United Nations Office on Drugs and Crime (2017). According to the report, science-based services and recovery programmes remain out of reach for many who have substance use disorders, and fewer than one in six have access to these services (United Nations Office on Drugs and Crime, 2017). According to Addiction Drug Alcohol Statistics South Africa (2012), rehabilitation following substance abuse and dependence in South Africa is estimated at 3%. This low statistic raises the question why South African recovery from substance dependence is so low. The question why certain individuals who are dependent on substances are able to experience a successful recovery process while others do not is affected by several variables. This is because individuals may have vastly different experiences of what assists them in recovery. Stewart (2010) mentions that support by family members and friends could be a helping factor in outpatient treatments but does not present evidence that this is in fact the case.

The focus of the literature such as Barlow and Durand (2012), and Myers, Petersen, Kadar and Parry (2012) is on methods of prevention rather than contributions to ongoing recovery. It is therefore necessary to understand what exactly may contribute to recovery from addiction, which would introduce sustainability into the literature.

Hari (2015) aptly explains the value of social support in his 2015 TEDTalk *Everything you think you know about addiction is wrong*:

> Looking at this, there was another professor called Peter Cohen in the Netherlands who said, maybe we shouldn't even call it addiction. Maybe we should call it bonding. Human beings have a natural and innate need to bond, and when we're happy and healthy, we'll bond and connect with each other, but if you can't do that, because you're traumatized or isolated or beaten down by life, you will bond with something that will give you some sense of relief. Now, that might be gambling, that might be pornography, that might be cocaine, that

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might be cannabis, but you will bond and connect with something because that's our nature. That's what we want as human beings. (05:52).

It is emphasised by Baumgardner and Crothers (2010) as well as Compton (2005) that social support is equivalent to a basic need. In other words, we require social support for our survival, and this is an asset in recovery from addiction. Considering the immense impact that substance dependence may have in the form of suicide, depression, financial problems and social isolation in particular, identifying the factors that may support or motivate recovery is vital (Central Drug Authority of South Africa, 2012).

Moreover, Stewart (2010) emphasises that families and other social support systems that provide understanding and security for the recovering individual may enhance the quality of the individual's recovery. Community projects aiming to decriminalise and reduce harm of substance use are seeing unexpected results when addicts are supported and educated about their habits and lifestyle choices (OUT, n.d.). Unexpected results include an interest in abstaining from substance use and advocating lifestyle change to other individuals with a substance disorder. These themes are also evident in the research findings.

For these reasons, the current study deals with a particularly underexplored topic and it is hoped that a contribution will be made towards filling this gap in the literature. The obvious lack of literature on this topic clearly leaves room to investigate the sustainability of recovery and the factors that contribute to recovery. One such factor is said to possibly be the support of one's direct systems; however, this is not supported by studies at this stage.

1.5 Aims and Objectives

1.5.1 Aim of the research

The aim of the research was to find out how family support plays a role in the ongoing recovery of individuals addicted to psychoactive substances.

1.5.2 Objectives

The primary objectives of this study are therefore:

- To establish how the participants define family.

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- To gain an understanding of the participants' experiences of the variables: family, support, recovery and addiction.
- To determine how they experience family support in their ongoing recovery process.
- To establish what the factors are that help them to express an interest in recovery, based on their experience.

1.6 Research Process

Qualitative research was identified as being most suitable for this study because it explored the experiences and views of participants. The study remains ideographic in nature, as it does not aim to generalise findings. The subjective experiences of individuals are explored and accepted as truth. Maree (2010) describes this form of research as naturalistic, as no variables are being controlled and the study explores the variables as they occur naturally. Because of people's value systems, beliefs, cultural backgrounds and contexts, we all experience and interpret situations differently. These differing interpretations do not make any party wrong or right, and researchers must accept these experiences as truth (Maree, 2010). Because of the qualitative nature of the study, statistical data is limited to the discussion of biographical details.

The study is explored from a systems theory point of departure. Luhmann (2012) views families as unique and complex systems. The interdependence of family members is undeniable and, as with other systems, disease in one part of a system affects the efficiency of the system as a whole. This study explores how family support and the family dynamic motivate recovery.

Research was conducted by means of individual face-to-face interviews. The convenience sample came about on a voluntary basis and by word-of-mouth referrals. The interviews were transcribed and coded. Thematic content analysis (TCA) was considered to be appropriate in facilitating commonly expressed experiences. Through the use of TCA data was able to be grouped such that themes could be identified in the participants' responses. These were then highlighted to identify specific common themes. The six phases of TCA as identified by Braun and Clarke (2006) are discussed extensively in

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Chapter 4, where the research methodology is explained. The findings of these specific themes are also discussed extensively in this manuscript.

1.7 Chapter Outline

Chapter 1 described the contextualisation, orientation and aims of the study and provided an overview of the research process. The second and third chapters focus on a review of existing literature on the variables to be explored in this study: family support, addiction or substance dependence, psychoactive substances and family. These chapters also touch on the current global focus on decriminalisation and the reduction of harm of substance use, the accessibility of basic and mental healthcare, and the responsibility of families as systems to support those with substance disorders. Gaps in the literature are discussed, and the ways in which the current study endeavoured to fill some of those gaps are explained. Chapter 4 expands on qualitative research design and methodology – the paradigmatic point of departure here being systems theory – and the sampling procedure used. Data collection, data analysis, rigour and the ethical considerations of this study conclude the fourth chapter. The results of the study are discussed in Chapter 5, focusing on the demographics of the participants, the difficulties encountered, and the prominent themes identified from the face-to-face interviews. The sixth and final chapter encompasses conclusions and recommendations relative to the results of the study. The final chapter also explores possible options for further research in this field.

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Chapter 2: **Literature Review: Substance Dependence**

2.1 Introduction

This chapter plays an important role in contextualising the need for the current study. It aims to provide information on the various elements that comprise substance dependence and its effect on all facets of an individual's life and systems. The societal impacts of substance-related incidents are vast. These are discussed extensively in order to create an understanding of the need for sustainability when it comes to the treatment and support of substance dependent individuals. Addiction is discussed in terms of its classification as a disorder by the American Psychological Association (APA), as are the varying degrees of substance use ranging from tolerance to dependence. Secondly, the types of psychoactive substances that are most used globally and their effects on the user are addressed. Disease and the spread of disease related to drug use are discussed in detail to illustrate the effect that substance use, abuse and dependence have on communities and societies at large. Finally, the gaps left by current literature are identified, and the ways in which the study proposed to fill some of these gaps are clarified.

2.2 A Global Perspective

Approximately 5% of the global population used a substance in 2015, according to the World Drug Report (United Nations Office on Drugs and Crime, 2017). It is estimated that 29.5 million of these individuals have a substance use disorder, which equates to 0.6% of the global population. These statistics give a clear indication of the availability and accessibility of psychoactive substances. This may be surprising to many, considering global policies and legislation against drug use and distribution. In view of the continuing high use of substances, changing policies such as decriminalisation and harm reduction strategies are being implemented in numerous regions of the world (Greenwald, 2009). This is discussed extensively in Chapter 3.

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Substance abuse has been carefully researched for many years (Central Drug Authority of South Africa, 2012). Studies of substance use have therefore become abundant. Young's (2009) study in the United States of America (USA) provides insight into the finding that recently incarcerated adult women are more likely to use or abuse substances (including alcohol) if they have had little social support throughout their lifespan. Although the study relates to the lives of incarcerated women, substance abuse is the chief focus (Young, 2009). Mokwena (2016) interviewed nyaope users in three South African provinces, in order to better understand their experiences. South Africa has a vested interest in the reduction of substance abuse, because substance use and abuse are twice the world norm in this country (Addiction Drug Alcohol Statistics South Africa, 2012). The Centre for Substance Abuse Treatment (2006) focused specifically on the challenges experienced in clinical settings of substance dependence treatment. Greenwald (2009) recently studied the effectiveness of substance decriminalisation in Portugal, which was the frontrunner in this movement. An abundance of research explores the disturbing effects that substance use and dependence have on individuals, families, communities and economies; however, little is said about the factors that aid successful recovery. A shift is evident in more recent research, however, in which some researchers are focusing on the sustainability of various treatment programmes rather than the effects of substance use and dependence.

The World Drug Report released its twentieth instalment in 2017. This report has been at the forefront of providing insights into global developments in the use of substances. The United Nations Office on Drugs and Crime (UNODC) publishes this report to support global efforts to provide information about usage and supply patterns as well as information about more effective ways of regulating psychoactive substances (2017). Health, security, development and peace are cited as the main focus of the 2017 World Drug Report. The World Health Organisation (WHO) has recognised the impact of drug use on the spread of HIV across the globe and has implemented efforts to eradicate HIV by 2030, specifically by focusing on policy development in terms of the reduction of harm of drug use. In order to understand the policies and procedures in place to support decriminalisation and the reduction of harm efforts, as well as the movement toward sustainable recovery, it is necessary first to understand the global impact of drug use.

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In the present study, the terms "substance dependence" and "addiction" are used interchangeably. Even though the term "dependence" is used, dependence without impairment of functioning is not implied. Although these are clinical terms, they are used in most recovery programmes. It must be stated that the current study does not intend to label participants but that, owing to the clinical nature of the study, it is necessary to use these terms. Substance dependence is a complex concept to unpack. The term denotes the use of various substances to the extent that such use impairs one's functioning in various areas. The American Psychiatric Association (2013) emphasises that, although one may be dependent on a substance, this does not necessarily mean that one is abusing the substance (for instance, one can be dependent on medication for health reasons). The explanation of addiction given above is very new, as it was previously referred to as "dependence", which was the case in many of the sources used for the present study. APA (2013) has various classifications for substance use disorders; based on the substance of choice, there are ten classifications according to the categories of substances. These ten classifications are "alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives; stimulants; tobacco and other substances" (APA, 2013, p. 481). These substances, to varying degrees, activate the brain's reward system through increased levels of dopamine, which is the brain's motivation or satisfaction centre (APA, 2013). For most people with a substance-use disorder, immediate gratification is a priority.

There are two groups of substance related disorders: substance induced disorders and substance use disorders. Substance induced disorders are intoxication and withdrawal, as well as a mental episode or disorder as the result of the use of medication or a substance. Substance use disorders, on the other hand, vary greatly and are classified according to the level of impairment of functioning. The two groupings or levels of impairment of functioning are described by APA (2013) as:

> Tolerance, where increased amounts of the substance are required in order to achieve the desired affect or "high"; and withdrawal, where various physiological symptoms occur when one ceases to use a substance. These symptoms can be eased with use of the substance again.

The APA no longer refers to "substance addiction" but rather uses the general term "substance use disorders" as an umbrella term. For the sake of the current study, the terms

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"addiction" and "dependence" are used to refer to those whose functioning is impaired by their use of a substance, as defined by Barlow and Durand (2012). Addiction constitutes a process, which Barlow and Durand (2012) explain as distinguishable stages of substance *use.* There are various levels of involvement of substance-related disorders. Substance use is described simply as the ingestion of substances that does not interfere with one's functioning, whereas substance intoxication refers to the physiological reaction to the ingestion of substances and results in impaired coordination. Conversely, substance abuse encompasses the extent to which *using* substances impairs one's functioning. Abuse of substances entails dysfunctional behaviour. Substance dependence or addiction refers to one becoming tolerant of substances, requiring ingestion of larger amounts to experience intoxication. Halting ingestion of substances at the level of dependence often results in withdrawal symptoms, that is, physical symptoms that can be avoided by ingesting the substance again or through continued abstinence (Barlow & Durand, 2012). It is important to note that not every individual who uses substances will advance to all levels of involvement of substance-related disorders (Sussman & Ames, 2001). Many individuals use substances regularly without becoming addicted. One example is individuals who use chronic medication to treat a clinical illness. Although they are dependent on the substance, they are not necessarily addicted to the substance. For example, an individual who must inject insulin to treat their diabetes depends on that substance to treat their illness but is not addicted to the insulin (Barlow & Durand, 2012). This is an important distinction to make.

It is also important to understand that the various classes of drugs have different effects on different people and on how each substance is used or ingested. According to the United Nations Office on Drugs and Crime (2017), various substances have varying effects on the individual, those surrounding them and the resources required to regulate these substances.

2.3 The Most Widely Used Substances

2.3.1 Cannabis

Cannabis is defined by Colman (200, p. 112):

> The psychotropic drug delta-9-tetrahydrocannabinol (THC) and related substances called cannabinoids that are found in the leaves, flowering tops, and

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> young stems of the female common hemp plant, *Cannabis sativa*, and whose biochemical action remains largely unknown...it is now a popular street drug, inducing euphoria, relaxation of inhibitions and intensifications of perceptions, with potential medicinal benefits, alleviating painful muscular spasms in people with multiple sclerosis, reducing the nausea and vomiting accompanying chemo-therapy for cancer, and reducing intra-ocular pressure in people with glaucoma. The cut and dried leaves, tops, and stems of the plant, rolled into cigarettes and smoked, are generally called marijuana; the dried resinous exudates of the flowering tops of the female hemp plant and the under sides of its leaves, when smoked with tobacco or added to foods and eaten, is called hashish; and the drink made from an infusion of cannabis is called bhang. The common street names for cannabis include dope, ganja, grass, joint, pot, reefer, spliff, and weed.

Cannabis is the most widely used substance globally. Use of this substance continues to increase in Africa, which is second only to the Americas in terms of the number of seizures of cannabis. This drug has become a controversial topic around the globe (United Nations Office on Drugs and Crime, 2017). Cannabis has a bad reputation as a gateway drug, with many claiming that its psychoactive effects are addictive. Owing to the addictive qualities and accessibility of this drug, it is believed that users move on to a stronger substance in order to experience a different "high". As discussed more extensively in Chapter 3, Du Preez (2018) explains that cannabis has officially been decriminalised by the South African Constitutional Court. It is, however, important to note that there are specific rules and regulations in place in respect of the amount of the substance allowable, its distribution and where one may use it. Cannabis is known by many names, including dagga, marijuana and weed (United Nations Office on Drugs and Crime, 2017).

2.3.2 Amphetamines

Colman's definition of amphetamines (2009, p. 30):

> A synthetic sympathomimetic drug that is often used as a street drug and as a medication to control the symptoms of narcolepsy in adults and attention-deficit / hyperactivity disorder and hyperkinetic disorder in children, and that acts as a stimulant, causing the release of noradrenalin and dopamine from noradrenergic

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> and dopaminergic neurons and blocking the reuptake of dopamine, leading to feelings of euphoria that can last for several hours, with occasional unpleasant side-effects, such as panic, anxiety, paranoia and insomnia.

Amphetamines (methamphetamine) are the second most widely used drug across the globe. Although methamphetamine has been found to be the largest contributor to the spread of disease, its use and distribution are not well documented in South Africa (United Nations Office on Drugs and Crime, 2017). Its use in continents such as Asia and America is most notable. Amphetamines can be ingested in different ways: orally, by injecting, snorting and, most commonly, by smoking or inhaling (ANON., 2018). According to the United Nations Office on Drugs and Crime (2017), the spread of diseases such as HIV, sexually transmitted diseases (STDs) and methicillin-resistant *Staphylococcus aureus* (MRSA) skin and soft tissue infections is highly prevalent. Cohen, Shuler, McAllister, Fosheim, Brown, Abercrombie, Anderson, McDougal, Drenzek, Arnold, Jernigan and Gorwitz (2007) explain that various factors make amphetamine users predisposed to contracting these conditions. Amphetamine users, like other addicts, may be living under adverse circumstances, depending on their level of usage. Homelessness and poor living conditions are common among members of this population group. They often end up living in poor conditions, resulting in poor hygiene and making it easier for the spread of skin infections, among other conditions. *An Overview of Substance Use* (2018) is an article written by an anonymous individual still in recovery. The article also explains that amphetamines create a feeling of something "crawling underneath your skin", which causes the drug user to scratch and pick at their skin. This is also a contributor to skin infections among this group of addicts. As a result of impaired decision making and cognitive functioning, HIV and STD transmission are also common, because hygiene is not necessarily a priority. This could also be as a result of sharing unclean needles and unprotected sex (Cohen et al., 2007).

2.3.3 Opioids

Colman (2009, p. 529) defines opiates and opioids as follows:

> Any of a group of substances that contain opium or an alkaloid of opium and that tend to have narcotic effects and are sometimes used as analgesics (1),

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anaesthetics (1), or cough suppressants. Also called opioids, especially when referring to the endogenous opioids produced naturally in the brain.

Botticelli (2016) has this to say about the use of opioids:

> Our current opioid epidemic and the AIDS epidemic tragically have much in common. Right now, we are in the midst of one of the greatest health crises of our time. During 2014 alone, 28,000 people died of drug overdoses associated with prescription drugs and heroin. (2016, 01:59)

Opioids such as heroin are the substances most responsible for the spread of health conditions such as hepatitis C and HIV among drug users. Opioids are ingested mainly by intravenous injection. People who inject drugs (PWID) suffer the most from the spread of disease, as hygienic injection frequently loses its place on a drug user's list of priorities. The National Institute on Drug Abuse (NIDA) (2018) explains that drugs often impair the functioning of the user, resulting in either sharing dirty needles or engaging in unprotected intercourse, both resulting in the spread of infections such as HIV, STDs, hepatitis C and other viral infections. Trigg, Kitchen, Chan, Willgoss, Sears, Aldhouse, Pierson and Scott (2015) recall from personal experience the disregard for using clean needles when they were addicts. The use of psychoactive substances further impacts the health of an individual, as the symptoms of diseases can either be masked or heightened by the use of substances, owing to one's weakened immune system (The National Institute on Drug Abuse, 2018). The sharing of dirty needles is a large contributor to the spread of these diseases. For this reason, hepatitis C is highly prevalent among PWID, particularly among opioid users (The National Institute on Drug Abuse, 2018). Most drug related deaths are attributable to the contraction of hepatitis C, having been shown to have more of an effect on drug users currently than HIV. PWID are also the marginalised group of drug users, who are most likely to experience a drug overdose, either fatal or non-fatal (United Nations Office on Drugs and Crime, 2017). Africa has seen a steep increase in the use of opiates, specifically in South Africa since 2012 and in surrounding countries such as Mozambique and Zambia since 2015 (United Nations Office on Drugs and Crime, 2017).

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2.3.4 Alcohol

The definition of Alcohol as on page 21 in the Oxford Dictionary of Psychology (Colman, 2009):

> Ethyl alcohol, a colourless, volatile liquid and central nervous system depressant drug that is produced by fermentation of sugar and is the psychoactive constituent of intoxicating beverages. Its pharmacological action, though not fully understood, is in part at least through the facilitation of the inhibitory neurotransmitter GABA, probably through stimulation of the GABA receptor complex. Although the absorption and bioavailability of alcohol depends on the body weight, sex, how recently one has eaten, plus several other factors, roughly one unit of alcohol (1/2 pint of beer, 1 glass of wine, or 1 measure of spirits) taken by an average 150lb (68KG) person generally leads to a blood alcohol concentration (BAC) of about 20mg/dl and produces measurable deterioration in performance on complex hand eye coordination tasks; two units taken in quick succession (alcohol normally being metabolised at about 1 unit per hour) leads to a BAC of 40mg/dl and produces in addition a deterioration in visual acuity; three units leads to a BAC of 60mg/dl and a loss of coordination; seven units leads to 140mg/dl and confusion, slurred speech, and ataxia...

Alcohol is a legal and widely used psychoactive substance. Owing to its addictive quality, addiction to this substance is not uncommon. Moreover, the fact that alcohol is legal and extremely accessible makes alcoholism an addiction that is difficult to overcome (Pathak, 2018). According to Addiction Center (2018), alcohol has historically been used in social settings and on celebratory occasions. Many people utilise the substance in order to relieve stress, unwind or commemorate special events. Use of alcohol often progresses to abuse and, in severe cases, addiction. Like illegal drugs, alcohol also triggers various neurotransmitters linked to one’s pleasure principles and results in the experience of gratification. Considering that it is a legal and wholly accessible substance, many people do not view it as a drug. Most people addicted to alcohol will only seek help once they have experienced a damaging event such as a car accident, memory loss or social disruption (Pathak, 2018).

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2.3.5 Prescription drugs

Prescribed drugs are also still commonly misused substances. Unfortunately, a poorly regulated pharmaceutical industry is a large contributor to this ongoing phenomenon. It is quite common for South Africans to be able to obtain prescribed or over-the-counter medication from numerous pharmacies without this necessarily being tracked (Anon., 2018). Most drug users use more than one substance to enhance the psychoactive effect and are known as polydrug users. Polydrug use remains dangerous, as users often end up endangering themselves and others through the use of substances that do not complement each other and may result in major health problems and overdose (United Nations Office on Drugs and Crime, 2017).

2.3.6 New psychoactive substances (NPS)

The 2017 World Drug Report explains that "new psychoactive substances" (NPS) are cause for increasing concern, as users are largely unaware of the contents of such drugs. Favaretto, Pascali and Tagliaro (2013) explain that NPS are also referred to as "smart drugs" or "legal highs" and consist mainly of "non-illegal" components and chemicals. King and Kicman (2011, p. 1) define NPS as "Narcotic or psychotropic drugs that are not scheduled under the United Nations 1961 or 1971 Conventions, but which may pose a threat to public health comparable to scheduled substances". Dosage of NPS has had an impact on substance-related disease, accidents and deaths. NPS prove even more difficult to regulate as contents are not specifically defined by legislation or regulation policies. Statistics around NPS are vague; however, the increase in the emergence of NPS since 2009 is notable. Increased usage of NPS is attributable to their affordability and accessibility, particularly for groups of PWID, those who are homeless or live in poverty and groups of low socio-economic status (United Nations Office on Drugs and Crime, 2017). NPS users are uninformed about the risks associated with untested substances.

A popular NPS in South Africa is nyaope. Mokwena (2016) explains that nyaope, whoonga and wunga are some of the terms used to refer to this NPS, which emerged in South Africa, specifically in Tshwane, between 2006 and 2009. Usage has spread rapidly to other parts of the country as well as to neighbouring countries. Nyaope, as it is referred to most frequently, is a combination of substances, and its composition varies greatly from

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one region to another. It most commonly consists of marijuana, heroin, anti-retro-viral drugs, rat poison and acid (Mokwena, 2016). It is also known to be mixed with detergent powder, pool cleaner, milk powder and bicarbonate of soda. Nyaope has harrowing effects on one's immune system, and withdrawal symptoms are also described as excruciating. Users of this substance describe the drug as providing a sense of euphoria and stress relief. It is well known among members of the communities who use this substance that it may take only once-off usage to become addicted. The substance is smoked by being lit and the fumes inhaled. Users explain that while using the substance, they can go without eating for days, resulting in a weakened immune system and malnutrition. The use of this substance is most common in rural areas of South Africa. As an NPS, possession and usage were not deemed illegal for some time – this changed in March 2014 (Mokwena, 2016). Accessibility and affordability play a major role in the widespread use of this substance. However, little information about the effects of this drug is available to the communities in which it circulates.

According to Mokwena (2016), nyaope is unique in that people in rural areas form communities around the substance – they support each other's usage and form gangs or groups in which they engage in criminal activity in order to support their habit. Recovery from nyaope addiction is described as exceptionally difficult. This is where COSUP in different communities has stepped in to make available the drug methadone, which assists in weaning nyaope addicts from the substance when they make an active decision to stop. Methadone is a drug used to prevent withdrawal from drug dependence. According to Potafio (2017), it has been successful in aiding recovery from substances such as heroine and has proven successful with nyaope recovery, too. Methadone Maintenance Therapy (MMT) has been successfully implemented by the World Health Organisation in reducing the harm of opioid use (World Health Organization, 2009). MMT is further discussed in Chapter 3. The service and medication are provided for a monetary cost, in order to ensure commitment from the substance dependent individual.

2.4 The Impact of Substance Use, Abuse and Dependence

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People generally start using substances (legal and illegal) as a response to drastic life-changes. These may be stressful situations such as exam stress, environmental changes like a move, job loss, divorce or the death of a close friend or relative. Sometimes even positive life changes such as a promotion may prompt people to use substances in order to help them cope with the demands of a new situation. What may start off as a coping mechanism often spirals into an addiction, meaning that the substance user is unable to function without the substance that helps them cope with stress, relieves nervousness, induces sleep or provides other similar perceived benefits. Besides leading to psychological dependence on a substance, many substances also cause physical dependence. People who have been addicted to a substance develop strongly rooted habits centred on obtaining and ingesting the substance of choice. Trying to get an addict to stop these behaviours is challenging, as it requires the person to rethink their general behavioural patterns – from something as simple as "What do I do when I am bored?" to who they associate with in social settings. According to Aging and Health (2016), risk factors for the use and abuse of substances include but are not limited to the following:

> … [having a] family member with an alcohol problem (family history), male sex, living alone, single status (separated or divorced), mental health issues, including depression or other chronic mental health problems, substance abuse in earlier life, chronic pain, sleep problems, life stresses (financial difficulties, retirement, loss of a spouse or family member, moving to a new home, new illness), being in the hospital, living in a long-term care facility, long-term tobacco habit, misunderstanding about how to take your medications, over-prescription of drugs that affect mood (especially for older women), not reporting unwanted medication side effects, disability and, finally, boredom. (par. 1)

The above risk factors cover a broad spectrum of possible reasons for drug use and abuse. South Africans have extremely varied socio-economic statuses, backgrounds and cultural inclinations. This means that these different groups of people have very different reasons for using and abusing substances. Aging and Health (2016) lists a variety of symptoms of substance use, abuse and addiction, ranging from physical symptoms to emotional problems, social problems such as job loss and even mental illness.

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Although the direct effects of substance use, abuse and addiction on the addict may seem obvious to many, the impacts are greater than simply affecting the individual who uses the substance. ANON. (2018) explains that there is a significant cost to society as a result of substance-related disorders: "...the costs involved with related healthcare resources, lost productivity, the spread of diseases, crime, and homelessness".

The most common way in which drug abuse is harmful to society is seen in crime rates. Crime rates are closely linked to the use and abuse of substances, in that theft and burglary become more common occurrences (Deitch, Koutsenok & Ruiz, 2000). Pierce, Hayhurst, Bird, Hickman, Seddon, Dunn, and Millar, (2017) conducted a study in which they researched the correlation between criminality or criminal behaviour and the use of substances, specifically opioids. It was found that there is, in fact, a direct correlation between drug use and engagement in criminal activity. The authors explain that there are various explanations for the co-occurrence of using drugs and criminality. Firstly, they explain that drug use may be the result of leading a criminal lifestyle, as opportunities for drug use are more prevalent. Secondly, it is said that criminality is the result of needing to fund the drug use as well as the result of the psychopharmacological effects of the substances ingested. Lastly, they explain that crime and drugs may be "cofounding": this means that there are common causes for both the use of drugs as well as committing crimes. In other words, this explanation would be that neither one is dependent on the other (Pierce et al., 2017). In desperate circumstances, thefts and burglaries can become violent. Although the criminal acts cause societal disruption, the consequence is also that valuable justice enforcement resources are monopolised by the effects of drug use and abuse (Deitch et al., 2000). This is true also for healthcare services, which are required for instances of overdose, injury and accidents as a result of substance use and abuse. According to drugrehab.org (n.d., para. 2), "drug abuse is associated with higher rates of foster care child placements, child abuse, college sexual assaults, prison sentences, and lost productivity coupled with increased work-related injuries". Although statistics suggest that there is a correlation between the use of drugs and crime, Riordin (2017) suggests that extensive longitudinal studies are required in order for related research to be conclusive. Her premise is that there is a higher concentration of reports on the use of drugs and engagement in crime, and fewer reports on drug use without a resultant criminal act (2017). She points out that one's upbringing, socio-economic

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status and other environmental factors play a role in one's tendency to behave criminally. This is, however, also true for the use and abuse of psychoactive substances (Riordin, 2017). Pierce et al. (2017) expressed a similar finding in their study, where they agree that longitudinal studies would be required to see whether criminality is a result of drug use or vice versa, or whether the two truly are cofounded due to similar or the same contributing factors in an individual's life.

All of these situations result in valuable resources and tax money being diverted to this problem, rather than being used for the improvement of the healthcare, justice or other valuable governmental services (United Nations Office on Drugs and Crime, 2017).

Although substance use has many consequences, the most extreme consequence is death, resulting from overdose, illness or negligence (Pierce et al., 2017). Diseases resulting from drug use, such as HIV / AIDS, hepatitis C and tuberculosis, not to mention mental health conditions that could result in suicide and overdose, are some of the factors contributing to the high death toll among substance users (United Nations Office on Drugs and Crime, 2017). Friedland (2010) and Sylvestre (2005) explain that hepatitis C remains a difficult disease to treat in substance users, owing to lack of access to treatment programmes and the risk of re-infections. PWID make up the majority of the population living with this infectious disease, the symptoms of which often only surface over time, which is an important point to note considering the risk of infections due to unawareness. The impact this has on drug users is substantial, as many are already living with weakened immune systems. Because this disease affects the liver, mortality rates related to hepatitis C and drug use are high (United Nations Office on Drugs and Crime, 2017).

Tuberculosis (TB) affects approximately one-third of the world's population, and the substance using population is particularly susceptible to contracting this communicable disease (Friedland, 2010). Substance users are already exposed to a number of adverse conditions, and TB is one more health issue being dealt with by this population group. King and Kicman (2011) explain that drug users frequently end up living in adverse circumstances, resulting in poor hygiene and close-quarter living. As a result, the spread of disease, especially something air-borne like TB, is almost inevitable (Trigg et al., 2015; Friedland, 2010).

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The spread of HIV / AIDS has been under the microscope since the beginning of the pandemic in the 1980s. The rapid spread of the disease and the effect it has had on various population groups, particularly in rural areas, has demanded the urgent attention of the world's powers (United Nations Office on Drugs and Crime, 2017). Although efforts to eradicate HIV and Aids have been unsuccessful, the education of the global population has slowed infection rates (United Nations Office on Drugs and Crime, 2017). The drug using communities, particularly PWID, remain a population group where the disease continues to spread, which is largely attributable to unprotected sex and the use and distribution of unclean needles (Cohen et al., 2007). Reduction of harm efforts, such as the distribution of clean needles, are in place in order to support the UN goal to eradicate HIV by 2030 (Greenwald, 2009; United Nations Office on Drugs and Crime, 2017).

The above health factors are some of the risks and consequences of substance use. Besides these biological factors, substance abuse also impacts a user psychologically and sociologically. In various ways and to varying degrees, substance dependent individuals may experience their day-to-day functioning as impacted. Eastwood and Rosmarin (2012) identify relationships – family relationships and friendships – as the most common aspects of life to be affected, as well as work, the sense of having a meaningful life, and general psychological wellness.

Relationships are largely affected by substance-use or dependence. Substance use is associated with stigma and legislation, giving rise to negative societal views of people who abuse or depend on psychoactive substances (Mokwena, 2016). Most family relationships and friendships involving a substance user suffer as a result of the user's behaviours. Alienation from families is not unheard of as a result of disruptive behaviour such as stealing, other criminal activity such as hustling, promiscuity, aggression and the behavioural manifestation of depression (Rosmarin & Eastwood, 2012). Seeing a family member under the influence of a psychoactive substance may also be generally disturbing, considering the lack of conscientiousness of an intoxicated individual. Pierce et al. (2017) explain that a substance user's criminal behaviour of often negatively affects those who are familiar with them.

What makes substance abuse such a maladaptive disorder is its impact on one's general functioning. It is not only relationships that are affected – one's involvement in other systems

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is also impacted (Rosmarin & Eastwood, 2012). Although unemployment in South Africa is a major concern, substance dependent individuals' work is often affected by their reliance on substances and how these substances affect their reliability at work. Fine motor coordination is negatively affected by numerous psychoactive substances and being under the influence of a substance could be a safety hazard in the workplace (Mokwena, 2016). Such situations are particularly common if the substance user manages to go to work despite their addiction (a situation known as functional addiction) (ANON., 2018). On the other hand, many individuals with substance use disorders do not prioritise going to work over the ingestion of substances, and in severe cases they completely neglect their work responsibilities, including responsibilities as basic as being at work on time (Trigg et al., 2015).

Other daily functions such as personal hygiene, general safety and seeing to one's basic needs of oneself and those of one's dependents may take a back seat in the life of an addict (Mokwena, 2016). Trigg et al. (2015) indicate that, as an addict, one's first priority is to obtain one's substance of choice, often leading to the neglect of personal, interpersonal and professional maintenance. This is particularly evident in the findings of the current study and was a prominent theme amongst all participants.

Given these numerous negative effects on individuals and society as a whole, efforts to treat substance abuse and dependence have been common and are continually evolving in an attempt to minimise or eradicate the effects of substance use, abuse and dependence. Substance use disorders are discussed in detail in Chapter 3.

2.5 Differing Profiles of Drug Users

The effects of drug use, abuse and addiction have been explored at length by various researchers and organisations (WHO, 2017; drugrehab.org, n.d.; ANON., 2018). Although most describe the negative effects on individuals, systems and society, there are also high-functioning or functioning addicts and substance users. Numerous public figures and celebrities have identified as functioning substance users. A functioning substance user is described as someone who is dependent on substances or abuses substances but still maintains employment, relationships and other systemic associations. Many admit to only

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maintaining these roles in order to ensure they are able to support their habit. For example, they realise that without maintaining employment they will not be able to afford their substances of choice. The following statistics (Bushak, 2014; the World Drug Report, 2017) are worth mentioning: white people are more likely to use substances than other races; men are more likely to use than women; and children of drug users are likely to be open to using substances later in life. Considering that people view substances and their effects as a form of stress relief, many people who suffer from depression or mood disorders appear to indulge in the use of substances – co morbid conditions (APA, 2013). Although it seems that some population groups are more likely to use substances than others, it is not clear what the specific contributors are to the use of substances by different population groups (Patrick, Wightman, Schoeni & Schulenberg, 2012). Myers et al. (2014) suggest that exposure, peer pressure and cultural norms play a major role in the prevalence of drug use amongst particular population groups. With reference to exposure, Myers et al. (2014) specifically elaborate on exposure to substances in cases where parents or guardians use substances, and the fact that this becomes acceptable in the eyes of the child.

Botticelli (2016) explains that he has been in recovery for two decades but still faces stigmatisation. He is a firm believer that there should be a greater, global movement toward treating addiction as a disease. He explains this as follows in his 2016 TEDTalk *Addiction is a Disease. We should treat it like one*:

> When I was nominated by President Obama to be his Director of Drug Policy, I was very open about my recovery and about the fact that I was a gay man. And at no point during my confirmation process – at least that I know of – did the fact that I was a gay man come to bear on my candidacy or my fitness to do this job. But my addiction did. At one point, a congressional staffer said that there was no way that I was going to be confirmed by the United States Senate because of my past, despite the fact that I had been in recovery for over 20 years, and despite the fact that this job takes a little bit of knowledge around addiction. (05:10).

2.6 Conclusion

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It is clear from this section of the literature review that the use of substances varies across the globe, not only in the type of substances used but also in the reasons for their use. It is also clear that, although substance use disorders have negative effects on the individual and society, there are also functional drug users who may not fit the general profile of a substance dependent individual or experience the stigma associated with substance use. Although the current study used a very specific sample of participants, this observation applied to them as well. Each individual had unique circumstances and a unique way of explaining their experiences. Although there was some overlap in terms of their situational factors and reasoning, they each had a distinctive story to tell. The current study specifically found out what this group of individuals had experienced and were experiencing, how their substance of choice – nyaope – affected them in their particular environments and, unexpectedly, what some of the health impacts were that they experienced.

The literature review continues in Chapter 3 by exploring the evolution of treatment approaches, the possible impact of decriminalisation and the reduction of harm, the relevance of viewing families as systems, and a description of the study's variables: family, addiction, recovery and support.

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Chapter 3: **Literature Review: Treatment Approaches and Families as Systems**

3.1 Introduction

By reviewing existing literature, this chapter explains how the current study aimed to address some of the questions about recovery from substance dependence that remain unanswered. The chapter explores the complex topic that is recovery from substance use, including various treatment methods for substance use disorders and how these methods are continually changing. The accessibility of science-based recovery programmes, the changing responsibilities of society, the reduction of harm and decriminalisation of substance use are addressed here. An understanding of families as systems and the dynamics of South African families in particular are essential. The chapter also discusses research that has documented the role of supportive structures in overcoming adversity. Family, addiction, recovery and support are the four variables explored by the study, and these are objectively defined in the literature review. To conclude, it is shown how the current study aimed to address some of the questions still unanswered by existing literature.

3.2 Historical Approaches to the Treatment of Substance Use, Abuse and Dependence

Botticelli (2016) makes the following point about treatment of substance use:

> Generally, people with other diseases get care and treatment. If you have cancer, you get treatment, if you have diabetes, you get treatment. If you have a heart attack, you get emergency services, and you get referred to care. But somehow people with addiction have to wait for treatment or often can't get it when they need it. And left untreated, addiction has significant, dire consequences. And for many people that means death or incarceration. We've been down that road before. For too long our country felt like we could arrest our way out of this problem. But we know that we can't. Decades of scientific research has shown that this is a medical issue – that this is a chronic medical condition that people inherit, and that people develop. (2016, 06:52)

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The way in which substance use disorders are treated has changed dramatically over time. This has largely to do with the perception of substance users and those who are addicted. According to Arria and McLellan (2012), the clinical understanding of substance use disorders is a very recent development. Seeing substance use disorders as disease and those who are addicted as being ill aids treatment tremendously (Henninger & Sung, 2014). The difference between seeing substance abuse as a sinful or deviant act and seeing it as disease is quite clear. One view implies a deliberate deviance from the norm while the other accounts for the physiological and psychological factors involved in addiction or substance use disorders. This is an echo of the description of substance use disorders as reclassified by the APA (2013). Although perceptions of substance use disorders have been slow to change, the treatment of addiction and related disorders has evolved rapidly. Various approaches to substance abuse treatment are discussed briefly below. This is not, however, the extent of the treatment that is available.

3.2.1 Detoxification and abstinence

Arria and McLellan (2012) describe detoxification and abstinence as lacking sustainability, as the initial removal of the substance of choice not only impacts the addict physically but also lacks any "aftercare" that might be necessary. Detoxification was always seen as the first port of call, removing any and all psychoactive substances or drugs of any kind from the addict's system. According to the National Institute on Drug Abuse (2018), the withdrawal symptoms of detoxification and abstinence could result in further physiological side effects as well psychological impact as a result of the traumatic experience. Although this method aims to remove the substances from the addict, the process should be medically assisted so as to avoid further harm. Aftercare such as psychological and behavioural treatments is recommended by numerous sources as reported by the National Institute on Drug Abuse (2018).

3.2.2 Narcotics Anonymous

NA has been active in South Africa since the 1980s. Anonymity is an aspect that NA prides itself on, as the focus is on recovering from addiction, rather than the behaviours of

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the addict (Narcotics Anonymous, 2018). This approach is multi-faceted in aiming to treat substance dependent individuals. It consists of a "sponsorship" system where a person who has managed to abstain from substance use is partnered with someone who is new to the programme. This facilitates accountability by the new member in that he or she works alongside the more experienced member to form new habits and a healthier lifestyle. Other interventions include the well-known 12 step programme as well as group and individual therapy sessions. People report positively on this method of substance use disorder treatment. The programme is extremely accessible, as there is no compulsory membership fee. NA appeals to many, as it guarantees anonymity and does not have any affiliation to particular religious groups or recovery centres, meaning that one can walk into regular meetings free of judgement or stigma (Narcotics Anonymous, 2018).

3.2.3 In-house rehabilitation

Also known as residential treatment, these are facilities offering 24-hour care to substance dependent individuals. The focus is on holistic treatment. These programmes are strict and look to re-programming the behaviour and thinking of an addict (Arria & McLellan, 2012). Most facilities such as these aim to impart life skills to the addict to enable them to build a way forward without the reliance on substances. Some facilities encourage a systems approach where each patient contributes to a different function within the rehabilitation centre (National Institute on Drug Abuse, 2018). Although rehabilitation in centres such as these has been successful in some instances, a general concern is that such an approach may not necessarily be sustainable. Not all drug-users will be able to maintain such a sheltered lifestyle once their time at the residential treatment facility has come to an end. Arria and McLellan (2012) also point out that residential programmes and in-house treatment are costly and therefore remain inaccessible to many individuals.

3.2.4 Therapeutic approaches

The most widely used therapeutic method for the treatment of substance use disorders, according to the National Institute on Drug Abuse (2018), is Cognitive Behavioural Therapy (CBT). The central focus of CBT is sustainability. This enabling approach aims to equip patients with the skills to identify possible, problematic behaviours that could

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lead to relapse. It enables patients to develop skills that would assist in developing new, healthier habits. Hawton, Salkovskis, Kirk and Clark (1989) describe CBT as an intervention to better regulate emotions and decision-making and to modify behaviours to overcome difficult times. This is particularly applicable to the treatment of substance use disorders (Williams & Martinez, 2008). Other therapeutic interventions include but are not limited to the psychodynamic approach, family therapy and talk therapy. Each form of therapy has its advantages. Deciding on the therapeutic method would largely be dependent on what works best for the patient in their specific circumstances (National Institute on Drug Abuse, 2018).

3.2.5 Methadone replacement

Although there are numerous medically assisted methods of treatment, methadone replacement or methadone maintenance therapy (MMT) has become widely used in the treatment of opioid dependence (Mattick, Breen, Kimber & Davoli, 2014). The aim of MMT is to assist the addict to remove the substance of choice from their lives and avoid the withdrawals and other physiological effects of removing the substance that they have become dependent on. This has been found to be an effective intervention for substance use disorders and is one of the better-known harm reduction strategies. Mattick et al. (2014) explain that methadone replacement has a place in weaning people off a substance, and the physical benefits make this an effective treatment. However, the cost of methadone replacement may mean that it is a less accessible form of treatment.

3.2.6 The reduction of harm and decriminalisation

A relatively new approach to the treatment of substance use disorders is the decriminalisation of substance use and reduction of harm efforts. European countries have been at the forefront of these efforts, but South Africa still has some way to go before truly realising the impact it may have. This approach is relative to the current study in that COSUP has initiated several such efforts. The following section of this chapter aims to expand on this multi-faceted approach.

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3.3 Harm Reduction and Decriminalisation Efforts

Hari (2015) says this about decriminalisation:

> I'd been thinking about it a lot lately, partly because it's now exactly 100 years since drugs were first banned in the United States and Britain, and we then imposed that on the rest of the world. It's a century since we made this really fateful decision to take addicts and punish them and make them suffer, because we believed that would deter them; it would give them an incentive to stop. And a few years ago, I was looking at some of the addicts in my life who I love and trying to figure out if there was some way to help them (2015, 00:13).

Law enforcement surrounding the distribution and possession of psychoactive substances is becoming increasingly effective according to the 2017 World Drug Report. It is estimated that the global interception rate of cocaine, specifically, increased between 45 and 55 percent in 2015 (United Nations Office on Drugs and Crime, 2017). Despite the increase in effectiveness of law enforcement, however, there has been a global movement towards the decriminalisation of substance use, as well as a focus on the reduction of harm that substances or the behaviours of the users have on themselves and others. Deitch et al. (2000) describe the positive impact of decriminalisation when it comes to the use of valuable resources such as police services, ambulances and healthcare. They explain there has been a concentration of governmental resources on the treatment or apprehension of substance related societal issues. With a move toward decriminalisation, these resources can be refocused on refining services and servicing other societal needs, such as disease prevention and treatment, education of communities in terms of health and crime, and focusing on criminal acts directly affecting communities (Deitch et al., 2000).

Murse, (2019) makes an important distinction between decriminalisation and legalisation and reminds us that these terms cannot be used interchangeably. A recent example is that although the production and sale of marijuana is still *illegal* (a criminal offence), in South Africa, small amounts for one's personal use is no longer seen as a punishable offence. Should the use of marijuana have been legalised, the government would have had to propose and implement regulations and taxations on the substance. The distinction is clear.

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Countries like Portugal, Netherlands, Belgium, Australia and numerous South American countries have been at the forefront of decriminalisation of psychoactive substances as a result of the high costs involved in enforcing these laws (Greenwald, 2009; Marlatt, 1996). It is important to note that decriminalisation does not equate to legalisation of substance use, possession or cultivation. Greenwald (2009) explains that, although decriminalisation is in place, there are still administrative penalties for the use, possession and cultivation of psychoactive substances. These could be in the form of fines or compulsory treatment. Very recently, South Africa initiated a trial period for the legalisation of the personal use, possession and cultivation of cannabis. The State has twenty-four months, from September 2018, in which to confirm the legislation of what constitutes the amount "for personal use" as well as the defining details of where one may ingest the substance. For many, decriminalisation carries the fear that drugs and crime will become rife in their communities. Successful decriminalisation and reduction of harm efforts have proved, however, that there are positive results to this approach (Greenwald, 2009). Rosmarin and Eastwood (2012) explain that the main reason for the decriminalisation of drugs is the "non-effect" that the war on drugs has had in terms of deterring drug use. They also explain that the financial cost and the negative impact on individuals and society as a whole contributed to the movement toward decriminalisation. Although decriminalisation has shown positive results, ineffective implementation of decriminalisation and reduction of harm policies can reveal skewed statistics to the alternative approach (Greenwald, 2009). This means that if communities introduce laws but do not physically implement them, it may appear that these efforts heed no results, when in actuality, they are not effectively implemented. The impact of criminalisation on individuals and society continues to be a lack of societal integration for the addict, the expense of detaining offenders of drug regulation policies, ongoing unemployment of substance users and a criminal record for the substance user. These are all signs that the criminalisation policies are ineffective, as there is no evidence that rehabilitation is occurring (Rosmarin & Eastwood, 2012).

With COSUP's harm reduction efforts, substance users are not ostracised for their behaviours but are assisted and educated in reducing harm caused by their habit to themselves and others. This approach is said to be far more effective as people are

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inadvertently educated on the impact that drugs have on their lives. The Reduction of Harm Coalition (2019; p. 1), explains:

> Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

There is much to be said for the acceptance of substance users in a non-judgemental setting at community centres such as the community centre in Mamelodi, one of the centres from which COSUP operates. The decriminalisation and reduction of harm efforts seem to centre around a level of acceptance of drug users that results in less alienation. COSUP specifically implements MMT as their main harm reduction and decriminalisation effort. The financial contribution that attendees make toward their treatment guarantees a level of commitment, the accessibility of the programme is a major advantage, and COSUP creates a safe, non-judgemental setting where these individuals are able to express their challenges. Although the possible negative impact of drug use is addressed, this is done without condemnation or judgement of the substance user's actions. Some argue that the fact that drug users are accepted, rather than reprimanded or alienated, aids in their wanting to learn about abstinence and could result in less tragic circumstances (Rosmarin & Eastwood, 2012). This is, however, speculation and these very recent policy changes still need to be implemented as intended before conclusions can be drawn about the pros and cons.

The concept of recovery may be described as overcoming disease or problematic periods (James, 2008). According to sources such as Anon, Barlow and Durand (2012) and Burke (2010), the concept "recovery" is strongly related to the field of substance dependence treatments. It is said that recovery from addiction is a period of growth and personal fulfilment. However, recovery can be extremely traumatic, as one may experience emotional turmoil, often even a sense of loss as a result of having lost friends and having to avoid

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familiar places, and blame and stigmatisation by others (James, 2008). Furthermore, the Central Drug Authority of South Africa (2012) explains that recovery from substance dependence is an ongoing process and that, once one has started to recover from substance dependency, one will always be doing so. With reference to the present study, "recovery" refers solely to individuals who have expressed an interest in recovery through the help of services offered by COSUP. Since recovery is ongoing, recovering individuals are referred to as being addicted to substances, even if they have abstained from use for prolonged periods.

Although in-patient treatment and lack of adequate facilities for recovery are addressed by Morojele, Parry, Brook, and Kekwaletswe (2011), no mention is made of the role that the family plays in recovery. A recurrent theme in recent research appears to be the factors that contribute to substance use and abuse, how these situations can be overcome, and the relationship between substance abuse and other abnormal behaviours (Morojele et al., 2011; Routledge 2005; Young, 2009). Although these are all extremely important topics from the perspective of prevention and awareness, the outcomes seem to lack sustainability, which the current study endeavours to address with regard to the possibility of direct support.

According to the World Drug Report (2017), only one in six people annually receive treatment for their substance-related disorder. At present, science-based programmes remain out of reach for many. These programmes focus largely on psychological and behavioural treatments. Stigma surrounding treatment may still be having an impact on people in terms of their wanting to reach out for help. Another factor is the cost of science-based treatment programmes. In South Africa very few individuals have access to specialised medical and psychological services, and the reality unfortunately is that government facilities cannot cater for the sheer numbers of people requiring these services (Mokgale, 2004).

The factors described above indicate that there is a shift of responsibility from healthcare professionals onto the shoulders of the family members or direct systems of the person needing treatment. Although this shift may be unintentional, it is a reasonable expectation that family members and even communities should take care of the individuals who form part of that system (Mokgale, 2004). Because treatment programmes remain

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inaccessible to many users, many families take it upon themselves to provide care as best they can.

3.4 Families as Systems

Addiction affects the lives of various people. It is not only the dependent person who is affected by his or her habit (Sussman & Ames, 2001). Barlow and Durand (2012) explain that addiction is an extremely destructive psychological disorder, as it results in broken homes, financial problems, and distrust, and can lead to other psychological problems such as depression. The far-reaching effects of substance dependence are undeniable and can be assessed by the severity of the physiological or psychological dependence (Barlow & Durand, 2012). Psychological dependence may be the most difficult to overcome, as the individual in certain cases has a set belief that the substance of choice adds to his or her life and that the effects thereof are less severe than they are in reality.

According to Strong et al. (2008), the family is the first system of which virtually every individual becomes a part. Although systems are broad and encompass most institutions that we are a part of in our lives, family remains a very intimate and direct system (Cox & Paley, 2003). Cox and Paley (2003) mention the nourishing role that family systems play within such a system. It is my opinion that this counts for one's psychosocial development and experiences.

Considering that responsibility for care is shifting onto families because of the growing inaccessibility of the healthcare system, it is clear that families and other social support systems fulfil varying roles when it comes to overcoming adversity and disease. Mayosi and Benatar (2014) explain that, despite constant efforts toward transformation, the healthcare system remains inadequate and is inaccessible to members of low-income South African population groups in particular. Although government healthcare systems are in place, the quality of these services leaves many without the care that they need. Besides immediate healthcare needs, psychological services such as science-based recovery programmes remain out of reach for the majority of the South African population. Mayosi and Benatar (2014) also point out that this lack of services has led to a shift in responsibility from the shoulders of

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healthcare professionals to the average member of society. This often means that friends and family members, employers and other community members shoulder the responsibility for basic healthcare, and that the care that many receive is substandard as a result. Systems theory as a theoretical point of departure is discussed in detail in Chapter 4, where its applicability to the specific system of the family is fully explained.

According to sources such as Botticelli (2016), Hari (2015) and Egan (2007), support from systems is an integral form of "informal help" that, often times, carries individuals through difficult times. In the context of recovery from substance dependence, there is a clear call for acceptance and unconditional support. This is obvious in the movement toward decriminalising drugs as well as in reducing harm efforts. The COSUP and OUT are exemplary of this. Organisations such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) (2018) also encourage the involvement of supportive systems – be it family members or friends. This culture of involving informal helpers, supports Hari's (2015) notion that unconditional love and support create an facilitating environment for individuals dependent on psychoactive substances. This is closely linked to Carl Rogers' theory of "Unconditional Positive Regard", which he said creates a safe environment for the client in order to see one's potential for growth or change as well as the potential for forward movement, to get out of less than ideal circumstances (Cherry, 2019). Rogers' approach is an established one and says a lot about what results one can expect if one regards others positively and unconditionally so. Hari (2015), Botticelli (2016), Rogers (Cherry, 2019) and Narcotics Anonymous (2018) advocate the fact that acceptance of individuals provides them with a sense of support which assists the individual in overcoming hardships. This is particularly important in overcoming addiction and the role that organisations such as the COSUP play are essential to making new ways in overcoming addiction.

Family members who assume more supportive roles in recovery have a great impact on the addict. It will be seen in later chapters that the current study uncovered how important the support of the participants' families was to them. Not only did it enable participants, materially, to undergo treatment, but it also impacted on their mindset. Hari (2015) agrees that addiction requires formal help, however, explains that with the support of loved ones – he does not specify family – one is more likely to be able to overcome the strongholds of

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addiction. The reason that this is easier said than done is due to the ever-present stigma that addiction to substances is still a sort of "choice" rather than a disease. Botticelli (2016) emphasises that changing this stigma will result in more automatic support, rather than blame. He argues that individuals and society understand that diseases such as cancer and diabetes require treatment and families stand by individuals who have been diagnosed, however addiction is not seen in the same light and is largely the reason that addicts remain unsupported and, as a result, do not get the help or treatment that is required. This thinking is quite recent and goes hand-in-hand with the notion that the "war on drugs" should be ended due to the immense resources required to fight this fight. It is said that the alternative approach would result in less drug-related deaths or serious illness and injury due to the unanticipated information sharing and education which is an automatic result of acceptance, decriminalisation, reduction of harm and unconditional support (Eastwood & Rosmarin, 2012). The Centre for Substance Abuse Treatment (2006) explains that many substance dependent individuals who enter their doors are alienated from their immediate support systems and look to the centre for a sense of belonging and community. The fulfilment of this need is on Maslow's "Hierarchy of Needs" and is fulfilled by a sense of connection (McLeod, 2018). Many believe that if this need is fulfilled and if addicts are unconditionally supported, they will more easily understand the need for recovery, in relation to shared values with their support system. Furthermore, a supportive and understanding system, would be able to assist the addict to identify which needs the addict is trying to fulfil by engaging with psychoactive substances and may assist them to find alternatives (Centre for Substance Abuse Treatment, 2006).

Supporting an individual who is challenged with addiction is not an easy responsibility, however, there are several sources who attest to the fact that this is the "missing link" in these individuals' journey. This is why the current study aims to find out what the participants' experiences are of family support and how this may have impacted their decision to seek treatment.

3.5 Variables

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Four variables are explained here for the purpose of this study. These variables are family, support, recovery and addiction.

According to Colman (2009, p. 276), the family is "the primary social group, comprising parents, their offspring, and in some societies other relatives sharing the same household; or more generally any group of individuals related by blood". This definition is appropriate for families in the South African context, specifically in South African informal settlements. However, one may question whether other social relationships are not perhaps closer than some family relationships. This is because individuals may experience family relationships as destructive or maladaptive. Strong et al. (2008) identify two types of family relationships: conjugal relationships and consanguineous relationships. Conjugal relationships may be described briefly as family relationships created by marriage (i.e. the relationship of in-law), whereas consanguineous relationships are those with one's biological family. Conjugal relations were explored by Durkheim, who described them as relationships based not merely on duty and emotional bonds, as in a biological family (Meyer et al., 2008). It is important to note the possibility that families may be an extremely negative or destructive presence in an individual's experience. In this study, family may include relatives, friends or other social acquaintances that fulfil the perceived supportive role of family members.

To conceptualise the second variable, namely support, it should be borne in mind that support in the context of family and addiction is deeper than the general understanding of support being a "crutch" for another individual. Support is defined by Colman (2009, p. 1504) as "help and kindness that you give to someone who is having a difficult time". According to Strong et al. (2008), "support" entails the provision of emotional stability for an individual or group. Support in the context of this study is therefore viewed as the ways in which family members are available to the substance dependent family member. This support may be in the form of emotional support, rehabilitative support or other forms of support as subjectively identified by participants. As stated by James (2008), during a traumatic period it is essential that one be supported by one's closest ties. Egan (2007) also notes that social ties, such as family ties, could be "informal helpers" in times of need, as opposed to "formal helpers" such as counsellors or psychologists. According to Egan (2007), it is not recommended that one rely solely on informal helpers, but such helpers

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may be of great assistance in overcoming hardships. In the context of South Africa, informal helpers, such as friends, family members and colleagues, tend to shoulder a lot of responsibility, considering the inaccessibility of psychological healthcare services and healthcare services, in general (Botticelli, 2016).

At this point it should be stated that, in the light of the above definitions of family and support, family support is the major focus of the present study. It should also be borne in mind that interpretations of family support may vary from one participant to another. For this reason, I was prepared for the possibility that families might be seen as encompassing more than the conventional definitions. For example, some individuals may see a very close friend as their own brother. However, the fact that the focus is on family support does not exclude this "brother's" support from the study. It is therefore necessary to consider the possibility that "family support" may be a subjective term. Moreover, the possibility that families may be perceived as maladaptive factors must also be considered (Strong et al., 2008). The focus, being family members does narrow the study, somewhat; however it was important to have a "starting point" to begin to fill such a large gap in the literature. Further study may expand to include social support, in general and may include all forms of informal helpers in order to see how applicable the outcomes of this study are to other contexts.

Recovery is "the process of becoming fit and healthy again after an illness or injury" (Colman, 2009, p.1241). Although this definition is relatively simple, it is nevertheless relevant, as societal stigmas often discount the fact that substance-related disorders truly are disease rather than intended deviance (Henninger & Sung, 2014). White (2007) emphasises the need for sustainable recovery interventions and mentions the fact that this is a multi-faceted programme and should include an integrated approach. According to White (2007), the focus should be on assisting the addict to reframe their thinking and behavioural patterns in order to adjust better. Botticelli (2016) also supports this point, equating addiction to treatable (not necessarily curable) diseases such as cancer and diabetes.

Addiction has been extensively defined above as per the APA's criteria (2013). Colman (2013, p. 18), however, simplifies it as "a strong need that someone feels to regularly take an illegal or harmful drug". As discussed in Chapter 2, addiction is complex, and its definition has evolved over time. The participants also reflected the complexity of addiction as it was relevant to their lives. Not all participants related to all levels of substance disorder, being

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use, abuse, tolerance and dependence or addiction. For many exploring NPS, it may take only one "hit" to become addicted.

From the above discussion, it is evident how the topic of this research has been underexplored over the years. As Stewart (2010) emphasises, families that are willing to support their substance dependent family members are commendable and may provide the necessary change in the lives of substance dependent individuals.

3.6 Conclusion

The current study aims to address the gaps in the literature identified by this extensive review. Although substance regulation is undergoing constant review, it is still pertinent to find out what factors contribute to ongoing recovery. It has been established that several factors contribute to ongoing recovery to varying degrees. This study focused specifically on whether or not the support of family members was a significant factor contributing to the participants' expression of interest in recovery. The study therefore determined the following:

- how participants define family;
- the participants' experiences of the variables: family, support, recovery and addiction;
- how family support is experienced in their ongoing recovery process; and
- what factors prompted them to express an interest in recovery.

The research adequately addresses these points and has to some extent filled the identified gaps in the literature, in that way providing opportunities for further research.

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Chapter 4: **Research Design and Methodology**

4.1 Introduction

This chapter explains the qualitative method of data collection and why this, rather than quantitative study methods, was employed. The study design – a case study consisting of multiple cases – is outlined, with an explanation of why this design was considered appropriate. The process of data collection is discussed, including the convenience sampling procedure, the inclusion criteria and the use of thematic content analysis to analyse the data. This is followed by a contextualisation of the theoretical paradigm, systems theory, relative to the current study, and an explanation of the measures adopted to ensure the rigour and the ethical integrity of the study.

4.2 Research Methodology

The research methods and theoretical paradigms outlined below were employed in order to find out what the experiences were of individuals addicted to psychoactive substances in relation to their family support.

Qualitative studies eliminate the need to identify a definitive cause-and-effect relationship (Foxcroft & Roodt, 2009). The works of Foxcroft and Roodt (2009) and Gravetter and Forzano (2009) indicate that qualitative research is largely applicable when conducting research in the behavioural sciences. According to Gravetter and Forzano (2009), a qualitative study is generally different from a quantitative study. In a qualitative study, the research takes place in a more natural setting, the perspectives of participants are taken as factual contributions to the study, and the study may be approached from a constructivist viewpoint (Maree, 2010). For these reasons, qualitative methodology was identified as most suited to the current research in order to meet the aim of the study. The study has been defined as ideographic, and thus descriptive methods are used to identify subjective experiences The subjective experience of participants cannot be measured against a predetermined standard. Qualitative research allows for a diverse range of data collection

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through face-to-face interviews, document exploration, audio-visual media, and any symbols significant to the participants (Gravetter & Forzano, 2009; Maree, 2010). In the current study, face-to-face interviews were the source of data collection. Research results and conclusions were entirely dependent on the subjective interpretations of the substance dependent individuals. Moreover, there was no experimental aspect to this study.

The nature of the study is strictly ideographic, that is, descriptive methods are used to describe subjective experiences. Uniqueness is also a characteristic of an ideographic study, meaning that there is an understanding that circumstances and experiences are unique to each individual and system (Foxcroft & Roodt, 2009). There is no intention to establish generalisable principles. The aim of the research can be reiterated as investigating whether the individual who has expressed an interest in rehabilitation experiences family support as playing a role in their ongoing recovery. According to Foxcroft and Roodt (2009) and Maree (2010), the absence of any intention to establish a general law limits the study to an ideographic approach and therefore reinforces the need for qualitative methodology. The qualitative research approach used a case-study method, as the experiences of multiple individuals in similar circumstances were explored (Nisrin, 2011). According to Nisrin (2011), the fact that a comparison was drawn from multiple cases in a single study makes this study a collective case study. This is further discussed under the research design later in this chapter.

The use of a qualitative study structure yielded rich quality data (Foxcroft & Roodt, 2009), as participants were allowed to speak as much as possible about their experiences and how these had changed during ongoing recovery. The exploration of participants' views provided insight into what they believe had assisted them during the course of recovery. This could only be done through qualitative research, as questions were deliberately open-ended and left room for any information that might not have been covered by a closed question. This provided participants with a sense of freedom to expand on their thoughts through being stimulated by well-formulated questions.

The factors identified were the participant's definition of family support, what was perceived as support, interpretations of recovery, and what can be regarded as addiction. These were discussed in detail in Chapter 3 and will be discussed further with the study findings.

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4.3 Study Design

According to Baxter and Jack (2008, p.544), the qualitative case study "is an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources".

A case study research design was best suited to the current study. The use of numerous face-to-face interviews identifies the study as a case study design with multiple cases. A case study is well positioned to yield rich data. By means of case studies, one is able to explore the research question by understanding the experiences and perceptions of the participants without controlling the variables involved (Maree, 2010). Baxter and Jack (2008) explain that there are several ways to decide when a case study design should be utilised. Firstly, a case study should be employed in answer to "how" and "why" questions (Baxter & Jack, 2008). The research aim of the current study provides adequate justification for the use of a case study method: "To find out **how** family support is experienced as playing a role in the ongoing recovery of individuals addicted to psychoactive substances". Secondly, a case study method is used if variables are not influenced during data collection (Baxter & Jack, 2008). The current study simply aimed to gain insight into the experiences of the sample, and no variables or conditions were manipulated during the interviews. Interviews and questions were largely structured in order to understand the viewpoints of the participants, and no controls were in place. Thirdly, Baxter and Jack (2008) explain that if context is an important factor to note during research, a case study is appropriate. This is clarified by the observation that contexts only become known to a researcher in unique circumstances and if they are believed to influence the experiences of the sample being studied. The current study used a very specific and unique sample. Because of the communities that form around the use of nyaope and the fact that COSUP utilises Methadone Maintenance Therapy (MMT), context is relevant to the outcomes of this study. This point also supports the choice of a case study research design. Finally, a case study is called for if it is unclear how the context influences the research question (Baxter & Jack, 2008). The last point is also relevant to the current study. Before research commenced it was unclear how the particular sample group would answer these questions. It is clear from the results that the environment and other contextual

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factors had an impact on the participants' experiences of family support in their journey to recovery.

The current study is further identified as a multiple case study. This means that it was a study not only of an individual case but of multiple cases, as evidenced by the multiple interviews that were conducted. The sample, or multiple case study, resulted in uncovering various viewpoints, which were accepted as truth and noteworthy for the study. The outcomes of multiple case studies lend themselves to transferability of findings, which is discussed later in this chapter. Multiple cases enabled me to draw comparisons between the findings and also open this field for further study.

4.4 Theoretical Point of Departure

As the research aimed to determine whether or not family support plays a role in the recovery of addiction, the theoretical point of departure implemented was systems theory. Families are most individuals' first introduction to the many systems that we become a part of throughout our lives (Becvar & Becvar, 1999). Families are a complex example of a system. Forsyth (2010) explains that systems are characterised in various ways and suggests the following questions to ask in order to determine the type of system being studied:

- Is the group predictable?
- What level of cohesion is observed?
- Are you examining an enmeshed or disengaged system?
- Is the adaptability of the group defined as rigid or chaotic?
- Is this a spontaneous or an organised system?

Answering the above questions in the context of a family makes it easier to understand why this paradigm was chosen for the study. Families are predictable in terms of the mores and value systems that are established in the group. If behaviour falls outside of these norms, a degree of unsettlement is experienced. Cohesion in families varies greatly from family to family (Gilles, n.d.). Members of adaptable family systems may perceive a greater level of cohesion than those of maladaptive or unsupportive families (Stern, 2015). Adaptive families are more enmeshed than maladaptive ones, which may be described as disengaged. Adaptability goes a long way in a family, as all family members grow into

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various stages of development and for this reason a certain level of adaptability is required. Weathering or adapting to changes will be different depending on the kind of change the group undergoes. If a family structure is rigid rather than chaotic, it is likely to remain a system rather than disengaging. Gilles (n.d.) and Stern (2015) both describe the fact that, although the intention of families is usually to be a unit or a system, the opposite can be true as well. It should therefore be emphasised that, although functional families operate as an enmeshed system, not all families are functional systems and some may be experienced as maladaptive by the members of the system.

Systems theory has been extensively explored by various theorists and simplified by Luhmann (2012). Luhmann's version of systems theory is highly applicable to the proposed study, as he focused on social systems specifically. The points discussed below indicate that this theory is highly relevant to family systems.

The participants in this group identified various forms of family systems in the description of their experience of the variable "family". These differences are explained in the study findings of the study in Chapter 5.

Cox and Paley (2003) explain that various interactions, be they marital relations or parent-child interactions, impact the system as a whole. These interactions or exchanges of information are described by Meyer et al. (2008). This resonates with Becvar and Becvar's (1999) use of systems theory to focus on collaboration between individual and family and between that family and the larger system of society (Stern, 2015). The main point here is that one unit in a system has an impact on the whole – individuals do not act in silos, and to some extent all are interdependent (Forsyth, 2010).

This theoretical framework was selected because families are a clear representation of the interactional approach, characteristic of systems theory, described by Forsyth (2010), Meyer et al. (2008) and Stern (2015).

Luhmann (2012) identified the following factors characteristic of systems theory. Firstly, Luhmann (2012) maintains that systems theory is applicable to all social and behavioural sciences and is construed from these sciences. He explains (Luhmann 2012) that the theory was developed to enable the use of an individual's subjective view as an objective truth, as truths are subjective – a point highly relevant to the multiple case study research design employed in the current study. Finally, in relation to the current study, Luhmann (2012)

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describes factors within a socio-cultural system as the result of processes within relationships (Ritzer, 2008). These factors are described by Luhmann (2012) and Stern (2015) as actions within a system that have an effect on the whole. In this study, this refers to the addicted individual's behaviour that affects the rest of the family, whether financially, psychologically or otherwise. The theory is said to be a scientific derivative applicable to all behavioural sciences (Luhmann, 2012); "family" is strongly related to the behavioural sciences, as can be seen from sociological theories. Secondly, the theory can be applied in varying degrees to both large and small-scale systems or groups. Each action within a system or group affects the whole, regardless of the group's size – for example, a birth that excites the entire family or a death that is mourned by a group of loved ones (Gilles, n.d.). Thirdly, systems theory regards all relationships within a system, no matter how varied, as significant. For instance, in the current study, these relationships may vary from sibling relationships to father–son relationships. Fourthly, processes can be derived from all aspects of a socio-cultural system. Lastly, Luhmann (2012) describes systems theory as dynamic, in that it is not restricted to application to systems of a specific kind. Rather, it is an all-inclusive theoretical paradigm (Ritzer, 2008).

Furthermore, Luhmann (2012) explains that it is important to identify which system is the subject of study, as mechanical, organic and socio-cultural systems vary greatly in their characteristics. The interviews conducted examine socio-cultural systems; a socio-cultural system is one in which interactions are based solely on the exchange of information rather than energy (Becvar & Becvar, 1999; Luhmann, 2012). Luhmann (2012) describes this as communication between elements of a system. The expectation, particularly in the context of the proposed study, is that families adapt to the negative circumstances of their substance dependent family members. They are able to overcome, as well as develop resilience to, these negative situations and re-establish relationships in order to be more constructive (Stern, 2015).

Meyer et al. (2008) describe systems theory as the acknowledgement that the whole is greater than the sum of its parts, something that Luhmann (2012) also states. This is further emphasised by Becvar and Becvar (1999), who explain that, although society is made up of a variety of interlinked systems, one becomes largely dependent on one's immediate system (i.e. the family). This is obvious to most people who have been through

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a difficult period of adjustment. It is often easier to adapt to situations when we are familiar with the individuals around us (Corey, 2009; Stern, 2015). This points to the system's openness to adjustment, adaptation, and the ability to overcome a challenge (Luhmann, 2012). This is clearly relevant to recovering substance dependent individuals. Recovery is usually a period of extreme transition in their lives, during which they require support and understanding, because they now need to take responsibility for previous actions, adjust to new patterns of living, and prepare to overcome possible temptations (Sussman & Ames, 2001). Stewart (2010) maintains that this period may be rendered less traumatic by an individual's immediate support structure, whether their family or social support system, and by the assistance, understanding and enhanced knowledge involved in such a structure.

As stated by Barlow and Durand (2012) in support of Luhmann's (2012) description of interdependent systems, addiction can cause major distress within a family, as it can lead to a complete loss of trust and even resentment on the part of family members. This is closely related to systems theory, which states that disease or disruption in one part of a system negatively affects the entire system or society (Becvar & Becvar, 1999; Luhmann, 2012). In the context of the current study, the disruption referred to is caused by the addicted individual, and the entire family is likely to be affected.

Once something such as substance abuse or dependence has permeated the safe boundaries of a family system, everyone is affected. In terms of systems theory (Luhmann, 2012), the family as a whole then becomes responsible for healing, not only to enable the individual to recover but also to re-establish the relationships destroyed through the behaviours associated with addiction. Stern (2015) describes this disruption or distrust within a family as a significant change from an open to a closed system, which is not ideal in the context of a family. In terms of systems theory, the system as a whole becomes responsible for its parts, for, just as each part is dependent on the system, so the system itself is dependent on its parts (Luhmann, 2012). This highlights the fact that socio-cultural systems exchange information through a variety of interactions – positive and negative (Luhmann, 2012). In these examples, the information being exchanged is mostly the disapproval of families regarding the addicted individuals' socially unacceptable, illegal and physically harmful behaviour.

The study was therefore conducted from a systemic point of departure, on the assumption that the ripple effect of substance dependence and the restoration brought about by the

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recovery process have an effect on the entire system, which is the family. Luhmann's systems theory provided the framework for the study. The relevance of Luhmann's (2012) view of communication and the significant effect it has on the adaptability of the system made this the most appropriate theoretical point of departure. The premise was that there is a particular exchange of information between the addict and their family members that leads the addict to perceive the support being provided, or the lack thereof. Moreover, the participants' views, although subjective, were accepted as truth, as Luhmann (2012) intended for this particular theory. All relationships were considered significant, even if they conjugal relationships (Stern, 2015). This indicated whether the above premise was applicable and, if so, to what extent it can be applied to families with substance dependent persons.

4.5 Data Collection

Data was collected by means of face-to-face interviews with willing participants. A Community Centre in Mamelodi is host to the COSUP project. The clinical associates acted as the first point of contact and information about the study. They were able to identify individuals who fitted the inclusion criteria for this study and refer them to me, so that I could explain to them what the study was about and confirm whether or not they would be willing to participate. For ethical reasons, I did not approach potential participants but waited for the references from the clinical associates. Once it had been established that participants understood the implications of their participation, the interview was conducted and recorded. I went through the aims of the study and explained how it was being conducted. Firstly, several biographical questions were asked and answered before moving on to the questions pertaining to the research problem. The questions were open-ended in order to gather as much subjective data as possible. The questions were supported by probing questions in order to make participants feel comfortable and validated and in order to obtain more information.

The interviews took place over two separate days or visits to the Community Centre and were dependent on the availability of potential participants who fitted the inclusion criteria and were willing to participate.

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4.6 Sampling Procedure

As explained above, the sample was based largely on convenience and participants' willingness to participate; the sample is thus a non-probability snowball sample (Gravetter & Forzano, 2009). Foxcroft and Roodt (2009) and Gravetter and Forzano (2009) describe non-probability convenience sampling as the most widely used method of sampling in a qualitative study in the behavioural sciences. Non-probability sampling is done informally to suit the methodology of the study. Although non-probability sampling has an increased tendency towards biased results, it is the most efficient method of sampling for this type of enquiry.

A sample of nine individuals between the ages of 20 and 35 years of age took part in the study. The sample size was sufficient and allowing for the point of data saturation to be attained. Within these interviews it was evident that themes started to repeat; indicating that data saturation had been reached. Participants from this age group were eligible because they were all within the Young Adulthood stage of psychosocial development identified by Erikson (Barlow & Durand, 2012). These individuals were all of similar socio-economic status which, in the case of the proposed study, would be middle-class individuals as defined by Statistics South Africa (2012). Because the researcher had little or no competence in all official languages of South Africa, all interviews were conducted in English with the agreement of the participants. These individuals had expressed their commitment to recovery by being part of COSUP. These factors all fitted the established inclusion criteria.

Cultural differences were also noted by means of a biographical questionnaire. The reasons for drug abuse in poverty-stricken population groups differ widely from those in wealthy population groups (Addiction Drug Alcohol Statistics South Africa, 2012). Very wealthy individuals often have easy access to drugs or use substances as part of their luxurious lifestyles, in which substances become habit-forming. On the other hand, those in poverty-stricken areas are known to use substances as an escape from their adverse circumstances or as a result of a lack of knowledge about the adverse effects of such substances (Patrick et al., 2012).

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The sample was a convenience snowball sample, as participants were not a predetermined group of individuals (Foxcroft & Roodt, 2009). However, those who were willing to do so referred other willing participants.

4.7 Data Analysis

Clarke and Braun (2013) and Braun and Clarke (2006), describe the versatility of thematic content analysis. According to them, some authors describe TCA as a phenomenological method of analysis, while they see this as a useful analytic method. Phenomenology within psychology is the study of subjective experience. It is an approach to psychological subject matter that has its roots in the phenomenological philosophical work of Edmund Husserl (1927). Because the aim of this study is to explore the subjective experiences of participants it is suggested that TCA is an appropriate method of analysis.

The flexibility of TCA as well as its applicability to numerous theoretical frameworks, enables this method to be used in numerous sciences, research interests and theoretical frameworks. Clarke and Braun (2013, p. 4), specifically describe the versatility of this analytic method as follows:

a) it works with a wide range of research questions, from those about people’s experiences or understandings to those about the representation and construction of particular phenomena in particular contexts;
b) it can be used to analyse different types of data, from secondary sources such as media to transcripts of focus groups or interviews;
c) it works with large or small data-sets; and
d) it can be applied to produce data-driven or theory-driven analyses

This method of data analysis was chosen for all of the above points. It enabled me to explore the experiences of the participants and the phenomenon of their use of nyaope within their context. This is exemplary of point a above. Transcriptions of face-to-face interviews were analysed, as applicable in point b. The current study included a small data set of eight complete interviews, which also supported the use of this analytic method (point c). Lastly, point d also mentions that it can be used for a theory-driven analysis – which is the case for the current study. The application of this analytic method is well-

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suited to the current study for all of the above reasons. TCA, specifically the model described by Braun and Clarke (2006) was therefore employed. Once the interviews had been conducted and recorded, the transcriptions were textually analysed using the six steps of Braun and Clarke's TCA model. Braun and Clarke (2006) describe TCA as a descriptive method of qualitative data analysis that assists in identifying patterns across data. It is important to understand TCA within the context of the current study. Anderson (2007) and Braun and Clarke (2006) explain that interview transcriptions are analysed textually by identifying common themes or patterns within the texts and point out that the importance or significance of themes should be contextualised to the entire data set rather than being limited by expectations concerning the research question. Although the research question must be the focus, it cannot eliminate themes that are not relevant to the question being asked. In other words, all prominent themes across the data set must be considered significant.

When applying TCA as demarcated by Braun and Clarke (2006), there are six phases of thematic analysis that must be applied. Although, these phases are numbered as "one-to-six" they are not dependent on one another and the researcher could repeat steps, if required. Clarke and Braun (2013, p. 4) quote these phases as follows:

> 1. *Familiarisation with the data*: is common to all forms of qualitative analysis – the researcher must immerse themselves in, and become intimately familiar with, their data; reading and re-reading the data (and listening to audio-recorded data at least once, if relevant) and noting any initial analytic observations.
>
> 2. *Coding*: Also a common element of many approaches to qualitative analysis (see Braun & Clarke, 2012a, for thorough comparison), this involves generating pithy labels for important features of the data of relevance to the (broad) research question guiding the analysis. Coding is not simply a method of data reduction, it is also an analytic process, so codes capture both a semantic and conceptual reading of the data. The researcher codes every data item and ends this phase by collating all their codes and relevant data extracts.
>
> 3) *Searching for themes*: A theme is a coherent and meaningful pattern in the data relevant to the research question. If codes are the bricks and tiles in a brick and tile house, then themes are the walls and roof panels. Searching for themes is a bit like coding your codes to identify similarity in the data. This 'searching' is an

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active process; themes are not hidden in the data waiting to be discovered by the intrepid researcher, rather the researcher constructs themes. The researcher ends this phase by collating all the coded data relevant to each theme.

4) *Reviewing themes*: Involves checking that the themes 'work' in relation to both the coded extracts and the full data-set. The researcher should reflect on whether the themes tell a convincing and compelling story about the data, and begin to define the nature of each individual theme, and the relationship between the themes. It may be necessary to collapse two themes together or to split a theme into two or more themes, or to discard the candidate themes altogether and begin again the process of theme development.

5) *Defining and naming themes*: Requires the researcher to conduct and write a detailed analysis of each theme (the researcher should ask 'what story does this theme tell?' and 'how does this theme fit into the overall story about the data?'), identifying the 'essence' of each theme and constructing a concise, punchy and informative name for each theme.

6) *Writing up*: Writing is an *integral* element of the analytic process in TA (and most qualitative research). Writing-up involves integrating the analytic narrative and data extracts to give the reader a holistic overview and to tell a coherent and persuasive story about the data, and contextualising it in relation to the literature review.

TCA was employed by highlighting any outstanding comments (identified through the patterns formed across the data set) and categorising them into a set number of themes (Braun & Clarke, 2006). The process was thus as follows: Once interviews had been conducted, they were transcribed verbatim using the recordings. The transcriptions were done by me in order to ensure that I was intimately familiar with the data set, as recommended by Braun and Clarke (2006). Thereafter, transcriptions were analysed to allocate codes to identified meaning units of data that stood out in each interview. These meaning units were identified to the extent that they related to the question set out in the aim. This is the second phase of TCA and is significant as it guides the final identification of themes according to the broader research question. Once meaning units of data had been coded in all the interviews, common *themes* across the interviews became evident.

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As Clarke and Braun (2013) suggest, the process of identifying themes is similar to the coding phase, however one can now identify patterns in each interview as well as across interviews in order to generate themes. Reviewing themes was the next phase and entailed, looking at all the themes and seeing which were closely related and, as a result, could possibly be "condensed" into an overarching theme. Penultimately, these common themes were then used to draw conclusions relative to the study. It was important to identify what story each theme told and how it was significant to the study. It became clear that there were themes identified across the interviews that were in line with the research question and some that were unexpected. Although there were some unexpected themes that were not necessarily integral to the aim of the study, these were noted in order to eliminate bias and to maintain the integrity of the study. The themes are further discussed in the following chapter, in which the results are discussed. The final phase, "writing up" gives context to these themes in relation to this particular study as well as comparable to existing literature. This phase of the data analysis process is evidenced by Chapter 6.

4.8 Trustworthiness and Rigour

Although the aims of a qualitative study such as this are different from those of a quantitative study, it is still very important to have measures in place to confirm the trustworthiness of a qualitative study (Houghton, Casey, Shaw & Murphy, 2013). The word "rigour" is defined by Colman (2009) as the quality of being "thorough and careful", and a researcher must be thorough and careful in research in order to ensure that it is in fact unbiased and confirmable. Denzin and Lincoln (2005) and Golafshani (2003) explain that qualitative case studies are unique in that data is not usually generalised or transferred to other contexts, but they point out that it remains important to conduct a high level of data capturing and dissemination. A rigorous case study will be characterised by credibility, dependability, confirmability and transferability (Houghton et al., 2013). According to Golafshani (2003), trustworthiness in qualitative research may be challenging to establish but not impossible. Denzin and Lincoln (2005) expand on these concepts in relation to qualitative studies. These concepts and the ways in which they were ensured in the current study are explained below.

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4.8.1 Credibility

Credibility in qualitative research is equated with validity in quantitative research (Denzin & Lincoln, 2005). Denzin and Lincoln (2005) view credibility as involving the use of well-established research practices, reflective rather than interpretive thinking, the researcher as a tool in the study, and a well-defined research question. To address credibility, the current study ensured the use of ethical and reflective research practices. Firstly, the research method and design allowed the individual participants' opinions and experiences to be accepted as truth and fact. Analysis of the data was reflective. As the researcher, my role was not to make inferences but rather to interview the participants and note their responses. Besides maintaining ethical conduct, it was important for me to remain neutral but accessible to participants. Lastly, the research question, aims and objectives were well defined and guided the research.

4.8.2 Transferability

According to Denzin and Lincoln (2005), transferability implies that the results of a study can be applied to different contexts. The transferability of qualitative studies is dependent on research design. In qualitative case studies, the inclusion criteria and sampling procedure play a role in the extent to which this transferability is achieved (Houghton et al., 2013). In view of the inclusion criteria, it would in fact be challenging to transfer findings to a dissimilar context, as a specific group and context were being studied. The current study does resemble similar findings in other academic studies in this field and therefore meets this criterion. It must, however, be said that the findings were specific to the sample under study, and I believe that one could expect other findings if the same study were to be conducted on a different demographic. It will therefore be seen that recommendations are made in Chapter 5 for further study. Although it is unclear how the findings of this study may be transferred to other studies, the multiple case study method was employed in order to track transferability from case to case. In the findings it is clear that the participants' responses are transferable between cases. This was a clear contribution to ensuring a rigorous and trustworthy study.

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4.8.3 Dependability

Credibility and dependability are closely related in qualitative research (Denzin & Lincoln, 2005). According to Denzin and Lincoln (2005), one cannot have dependability without credibility. Dependability is the possibility that the same research, if conducted again, would produce similar or the same results (Golafshani, 2003), for instance by means of focus-group discussions after the individual interviews. As discussed under transferability, I believe that this study has opened doors for further research. Having interacted with other studies of a similar nature, I do believe the results of this study are dependable, in that some findings resemble certain points made by researchers such as Mokwena (2016). Although I strongly recommend further research in this field, I believe that further interviews or focus groups with a similar sample would yield similar results. The outcomes of further research would be richer data and possibly confirmation that more groups have the experiences of the sample under study in the current research.

4.8.4 Confirmability

Confirmability has to do with the objectivity of the research conducted (Denzin & Lincoln, 2005). Golafshani (2003), however, states that this may be challenging, since qualitative research is conducted largely by means of questionnaires produced by the researcher. For this reason, it is important that the researcher should acknowledge their prejudices or expectations (Golafshani, 2003). In the context of the current study, this may be done by explaining that I perceived the family as a support structure equivalent to other forms of social support, such as my peers. In addition, I expected to find that families do play a role in the recovery of individuals addicted to psychoactive substances. These biases and expectations were managed by peer evaluation. My supervisor went through the transcripts and we discussed the identified themes to ensure, once again, that these had been identified objectively. Rather than being influenced by preconceived ideas, my awareness of my biases assisted in making sure that interpretation was eliminated.

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4.9 Ethical Considerations

Conducting research from a qualitative perspective can be complex, considering that the subjective views being expressed are accepted as fact. A strict code of ethics must be adhered to in order to ensure the wellbeing of the sample group and the researcher (Foxcroft & Roodt, 2009). The first consideration was that, as the researcher entering the community of participants, it would be unethical for me to go into the community with a grandiose sense of self. To ensure that the interviews went smoothly, I approached participants with an attitude of hoping to learn from them. Egan (2007) describes this as the “bottom-up approach”, adopted to make participants feel comfortable, validated and at ease. Foxcroft and Roodt (2009) emphasise that there must be collaboration, rather than direction by the researcher. It was therefore important that I did not express my opinions about the participants’ stories. As mentioned in previous chapters, the participants’ views and accounts of their experiences were accepted as truth and my non-judgement, empathy and validation of these experiences during the face-to-face interviews played a role in how comfortable participants were to disclose them to me. This meant that the research had to be conducted in such a way that it did not disrupt the lives of those participating (Bezuidenhout, 2009). Although participants took time out of their usual routines at the community centre, I aimed not to allow the interviews to be disruptive of their usual counselling and medical treatments while at COSUP. It is essential that the researcher have a sense of respect for the place they are in, for the individual, and for the prevailing norms (Allan, 2011). I accordingly waited for guidance from the clinical associates, who are familiar with the norms and mores of the community in which they conduct their work. It was essential that I did not approach the potential participants but that they were informed about the study by the clinical associates and could then decide whether or not they wanted to participate. Participation was therefore completely voluntary, which I believe contributed to the richness of the data collected.

Furthermore, although the questions used were of a sensitive nature, they were not harmful to the participants, and it was made clear that they had the option to discontinue participation at any point during the research. Foxcroft & Roodt (2009) point out that, in such a case, the personal details of participants who have opted to discontinue participation are not utilised in the study. The current study saw one participant who did

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not complete the interview, and although this is noted in the findings, no details of the questions answered by the participant may be disclosed.

The anonymity of participants is something that many of them enquired about. I assured them that, although the information they provided would be discussed in a research paper, their identities would not be disclosed. Since confidentiality in respect of information provided by participants is of the utmost importance, they were told how the information that they were providing would be used (Foxcroft & Roodt, 2009). Anonymity had to be the primary aim of the researcher in order to protect participants from exposure, as the study was sensitive in nature. It was therefore my responsibility to obtain informed consent from the participants (Bezuidenhout, 2009; James, 2008), using a form which each of them signed. The form stipulated that participants' identities would remain protected as far as possible, but that there would be a number of individuals handling the data and that complete privacy in respect of the data could therefore not be guaranteed.

Appropriate research practices, such as compiling information based on other sources, were followed ethically and without plagiarism. During the process of data analysis, I ensured that my views did not lead to an interpretation of the themes being identified, as interpretation had to be postponed until the results were discussed officially (Anderson, 2007). The findings of the current study are discussed in the chapters that follow.

Although the research aimed to determine whether it is possible to improve success rates in respect of rehabilitative processes, the aim was not for it to become an intervention. It was therefore made clear to all participants that it was not the researcher's responsibility to remedy their situations. The need for this arose when a participant asked if they could contact me if they needed someone to talk to. I explained that it would not be appropriate but that they had exceptional care available at COSUP and that, if they needed further referral, it was up to them to request this from one of the clinical associates. The participant accepted this and understood that it was the process to be followed. According to Allan (2011), managing the participants' expectations or understanding of your role as researcher will ensure that they do not have any unfounded hope that the researcher is a solution to their current predicament. The participants were made to understand that ensuring their anonymity, providing information about the progress of the research (if participants request this) and debriefing them after the interviews were part of my role while I was there. Debriefing is important, as

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interviews may give rise to anxiety as a result of having to deal with experiences from the past (James, 2008). In addition, the informed consent form contained referrals for further psychological assistance. During these interviews, this was not required.

4.10 Conclusion

The focus of Chapter 4 was to clarify how the research was conducted and how the integrity of the study was maintained. The qualitative research methodology was employed in order to ensure richness of the data, while the subjective views of the participants were accepted as factual contributions toward the findings of the study. The data was collected in order to ensure that the insights obtained from the sample could be explored. The face-to-face interviews enabled me to understand the participants' experiences by asking open-ended questions using a multiple case study research design. The convenience snowball sample ensured that participants were not victimised and that they were comfortable with the research process, before and during participation. The fact that participants were referred to the study by a known clinical associate, prevented them from being pointed out by an outsider and eliminated the possibility of feeling judged by someone who would not know there battles with substances without a trusted associate having told the researcher, me. TCA was employed to identify the themes, which are discussed in Chapters 5 and 6. Systems theory specifically applied to families was found to be the most appropriate theoretical point of departure for the current study. It is, however, important to note that differing family dynamics mean that not all families will be functioning systems and that some may be maladaptive. Various strategies were utilised to ensure the trustworthiness of the study, namely credibility, transferability, dependability and confirmability, all of which ensured that the study was conducted with integrity. Other considerations in this regard were the ethical principles maintained throughout the process.

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Chapter 5: **Results**

5.1 Introduction

This chapter provides demographic information about the participants in this study, represented graphically. The anticipated and unanticipated findings of the study are discussed, and excerpts from the verbatim transcriptions of the face-to-face interviews are provided, giving insight into how the primary objectives of the study were addressed by the participants' answers. Once the data had been collected, TCA was employed to identify the prominent themes and to compile the results of the study. Although some themes were not expected, they are mentioned as they add value to the study and are essential to the participants' frame of reference. As a result, this provides further insight into the results of study and the unique experiences expressed by the participants. The common themes are addressed in this chapter and any outliers are acknowledged.

5.2 Findings

Braun and Clarke's (2006) six phase thematic content analysis (TCA) was employed to analyse the verbatim transcriptions of the face-to-face interviews as discussed in chapter 4. During this process, familiarity with the data was important, coding was done and several common themes were identified. The demographics of the study are illustrated and described below and then the TCA process is discussed by means of step-by-step definition. Tables are included in order to clearly represent the process visually.

There were initially nine participants in the study. However, one of the participants left while the questions about his demographics were being asked, saying he would return, but he did not. This individual who was participant number eight shared much the same demographics as the rest of the sample but did not answer interview questions. Because this participant did not engage in the full interview, his details have been excluded from the study's results. The following demographics are therefore a reflection of the remaining eight participants who engaged in a full face-to-face interview. A discussion of the demographics

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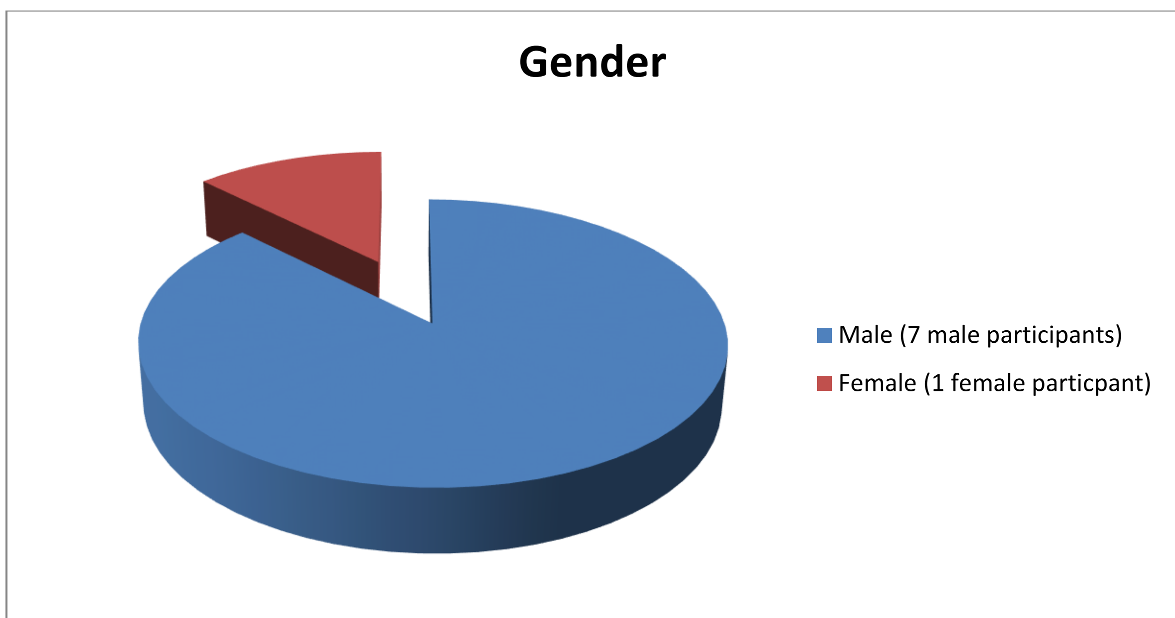
of this sample, illustrated graphically below, provides some context to the themes and primary objectives of the study discussed later in this chapter.

Of the eight participants who took part in the study, only one was female. She was a lot more reserved than the male participants. Because she was the only female, and given the qualitative nature of the study, it is not possible to draw conclusions about whether there would have been any commonalities or gender differences in this study. There were no notable differences between her answers and those of the male participants. On the contrary, all participants had a clear commonality in terms of their socio-economic status, living conditions, similar educational backgrounds and level of adult development.



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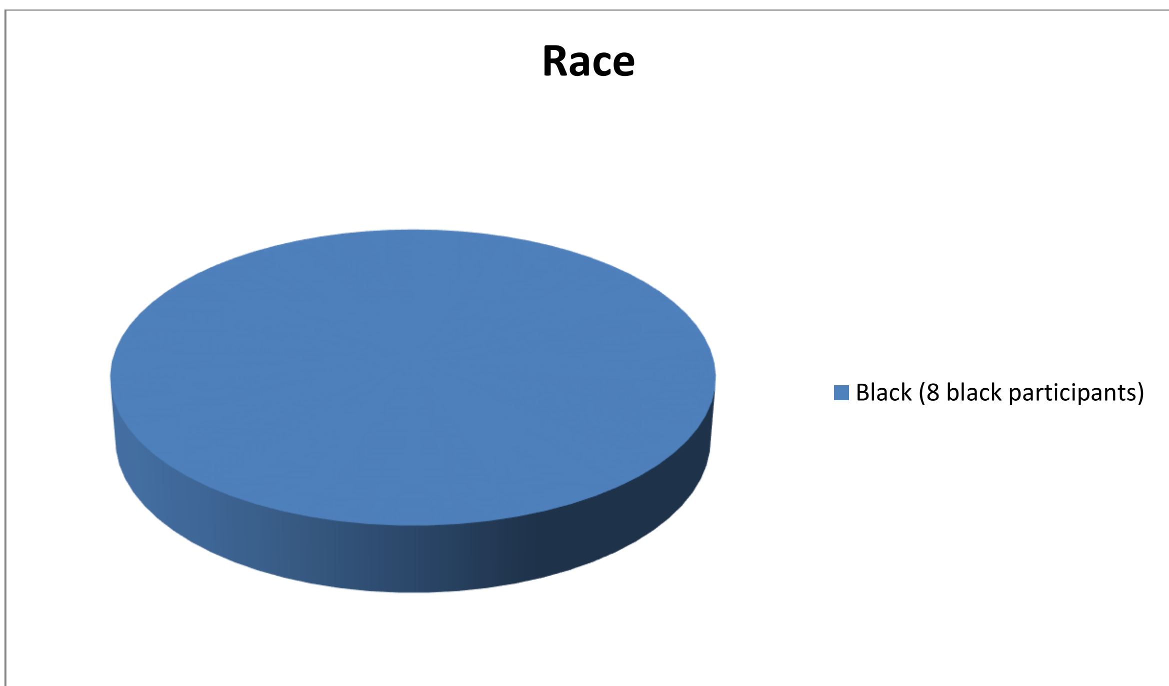
All eight participants were black, and all were South African. Fortunately, they were all willing to engage with me in English, despite it not being their first language. They were fluent in English and we had no trouble communicating. Participants all expressed a clear understanding of their rights and roles throughout our interactions. According to Statistics South Africa (2012), approximately 76.4 percent of the South African population are black. This sample is therefore representative of the majority of the South African population but excludes quite a number of racial groups from the diverse population. The members of the sample also came from similar cultural backgrounds in terms of how they live – residing in informal settlements – and the norms that come with this. There appeared to be a strong sense of community, in that they were aware of their place within a community and how people viewed them before, during and after substance dependence.



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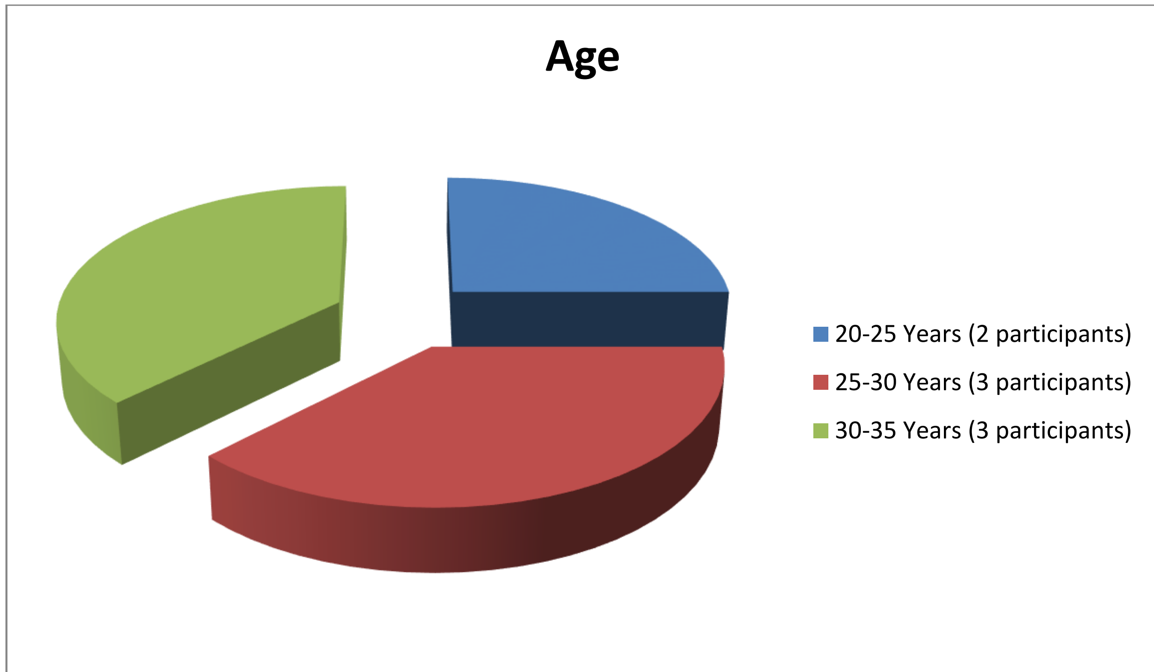
The youngest participant was turning 21 years old and the oldest was 35 years old. This means that all participants were within the Young Adulthood stage of psychosocial development as delineated by Erikson (Barlow & Durand, 2012).



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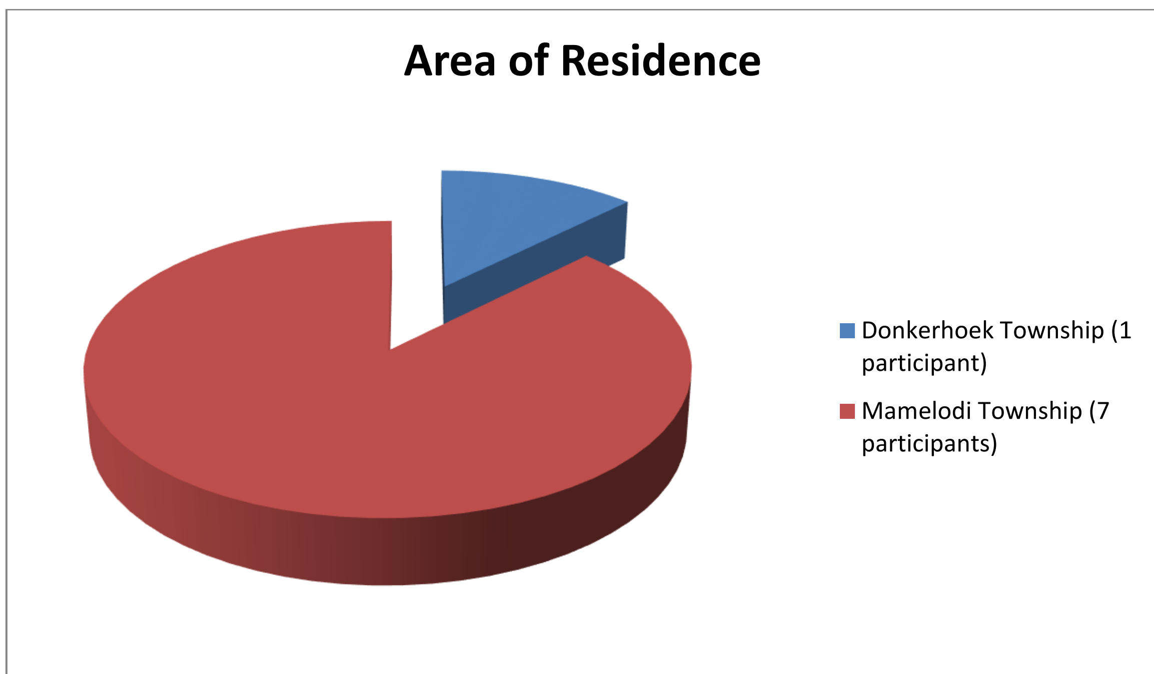
All participants resided in informal settlements. One was not from Mamelodi but resided approximately 10 to 11 kilometres away from Mamelodi, where the interviews were conducted, in Donkerhoek Township. He explained that he lived alone in the newly established informal settlement. Moloisane (2016) explains that informal settlements are constantly expanding, owing not only to natural population expansion but also to the ongoing migration of individuals to these settlements. This is due partly to ongoing poverty but also to the community support and joint incomes of the community and family members in these areas.



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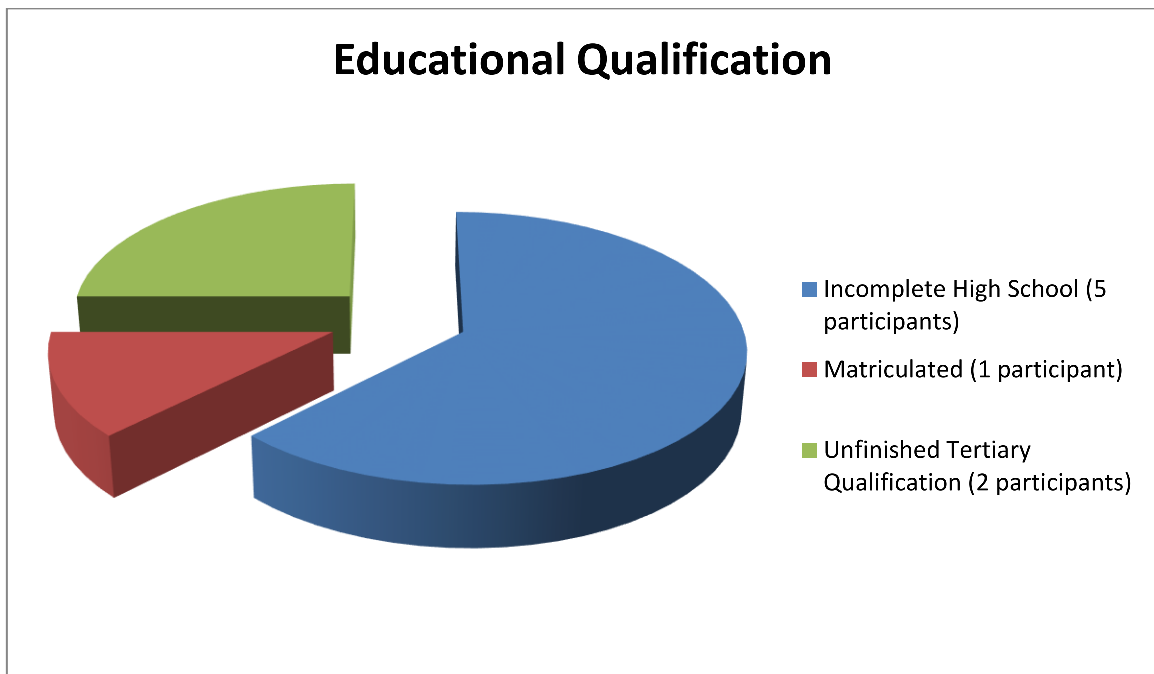
According to South African Market Insights (2019), South African youth continually struggle with unemployment regardless of their qualification level. Although the participants had different levels of education, they all expressed the importance of finding a job now that they were working toward recovery, and some were looking to further their education as well. Despite their differing levels of education, there were no notable differences in their experiences during their time of substance dependence. Their experiences appeared to be very similar.



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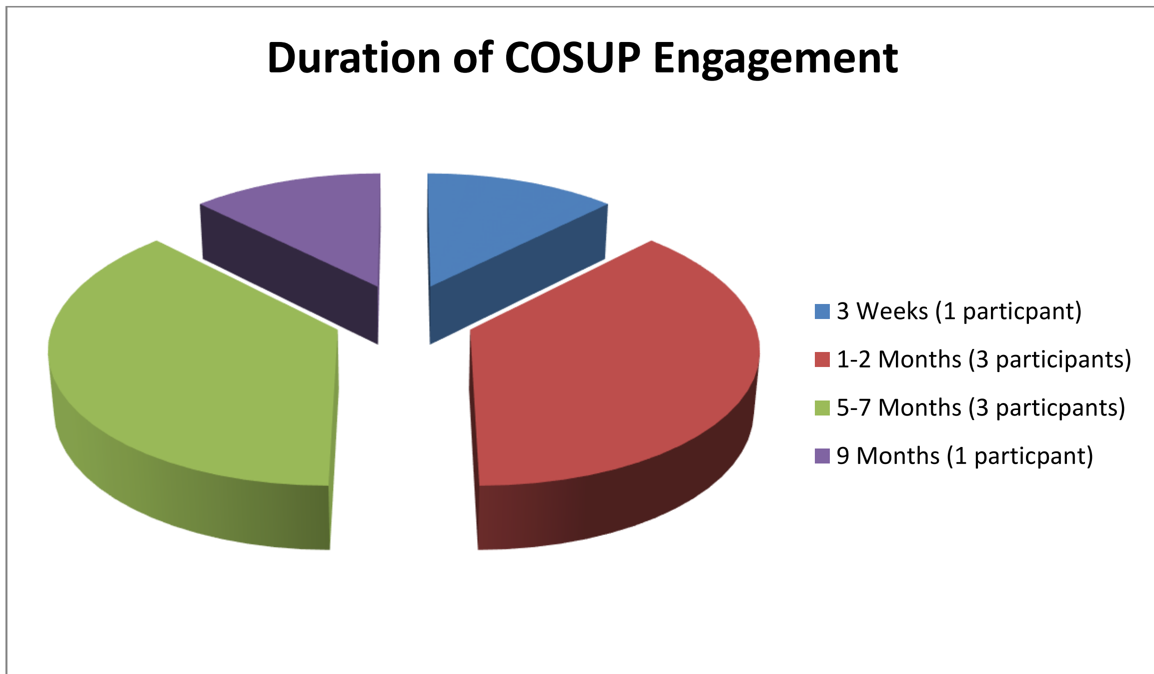
Discussion of their participation in COSUP elicited positive responses. Participant three said: "Yeah, I am very happy. I never thought I am going to quit this thing." Several participants were referred to COSUP by word-of-mouth. They expressed excitement about the support that they received at COSUP beyond MMT. There was special mention of the clinical associates (CAs) who engaged with the participants on a deep level, with one CA even inviting one of the participants to attend his church.



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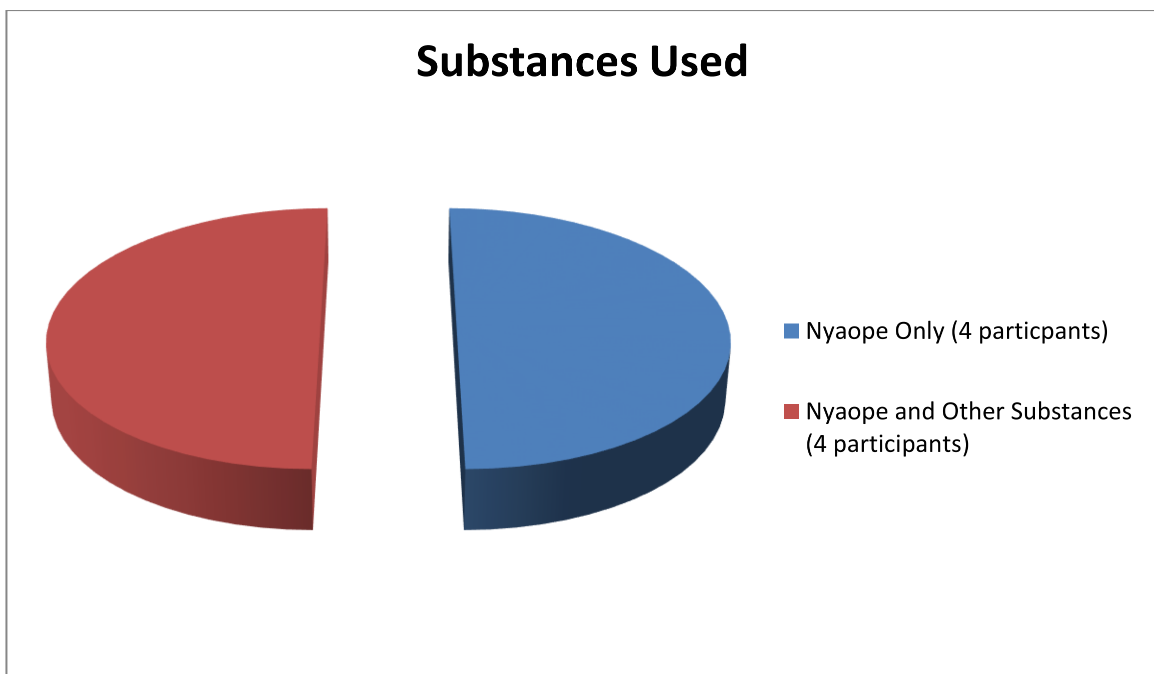
All participants disclosed that they had used nyaope. Four of the participants said that they used nyaope along with other substances such as cigarettes, "dagga" (marijuana), cocaine and "tik" (methamphetamine). According to Mokwena (2016), nyaope use and abuse is most prominent in Tshwane, where it originated. It was however interesting that every participant had used and was most fond of nyaope, in terms of the substances that they used. Although half of the sample were poly drug users, all participants indicated without hesitation that nyaope was their substance of choice. The fact that the substance is so accessible and so inexpensive meant it was unsurprising that all participants used nyaope, but it was notable that it was their substance of choice. When participants were asked what their substance of choice was, the answer came easily:

Participant nine: "Obvious, it's nyaope."

Participant six: "Because [of] without nyaope I couldn't deal with it, so I preferred nyaope."



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Although there were several contextual similarities, answers to the questions elicited some similar and some different responses. The participants had different natures, and some were more responsive than others. The prompting questions did help the researcher to obtain more information. Participant seven, the only female, was very shy in comparison to some of the other participants. There were unfortunately no more female participants to allow conclusions about the gender differences in this study.

Besides the demographic commonalities, several common themes emerged from the verbatim transcriptions. Identifying themes was a process of beginning with meticulously working through the transcriptions and highlighting the meaningful data points that stood out during the interviews. This initial phase is known as coding (Clarke & Braun, 2013). Initially, the coding process entailed going through the transcriptions, identifying points of interest and distinctive comments (meaningful data) made by the participants as a step towards being able to highlight "themes".

As I progressed through the coding process using the transcriptions, it became apparent that some patterns of meaningful data were recurring while others were less common. This is the third step after familiarising myself with the data and completing the coding. This is known as "searching for themes" (Clarke and Braun, 2013). The recurring patterns could be formulated as themes when they spoke directly to the research question, aims and objectives of the study. I noted themes in a spreadsheet, also marking which of the participants had expressed them. At this stage the themes could be reviewed and checked for relevance in the broader context of the transcriptions. This provided insight into the contexts and experiences of the participants. This was the way in which I conducted phase four of Braun and Clarke's analysis method; "reviewing themes" (Clarke & Braun, 2013). The table below illustrates the process:

Potential Themes	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P9**
Staying alone		X						X
My behaviours caused damage to my family.				X			X	X
Family is not a supportive structure ***anymore.***		X						X
Friends play a supportive role in my life.		X						X

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Eating well is a new priority.	X				X			X
I was not close to my family due to my drug use.		X				X		X
The drug was enticing because it would relieve stress.	X			X				X
When I was using drugs, I was stressed because I focused on getting my next fix	X			X	X	X		X
I didn't feel like a "normal, happy" person when I was using substances.	X		X			X		X
I had to hustle to support my habit.					X	X		X
I frequently felt ill, due to withdrawal symptoms.	X	X	X	X			X	X
I stole in order to support my habit.	X		X	X	X	X		X
I stole from my family.			X	X			X	X
I was arrested.								X
The decision to stop was because I had a difficult relationship with my family.		X	X			X		X
It is important that I get a job.	X	X	X	X	X	X	X	X
Regret certain actions while using			X	X				X
Regret using substances	X	X	X		X		X	
Regret the impact on family			X		X			
My family was upset by my use because it did not align with our family values.	X	X	X	X	X	X		X
Now that I am attempting to recover, I am closer to my family.	X		X	X		X	X	X
I no longer liked my lifestyle, I wanted to stop.	X	X	X			X		X
My family encouraged me to stop using substances.	X		X	X	X	X	X	X
Church / spirituality / prayer assist in recovery.		X	X		X			X
Methadone aids recovery.	X	X	X			X	X	
Family is a supportive system.	X		X	X	X	X		
Family support assists you out of bad situations.					X	X		

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I changed while using substances.			X		X	X		
Family / friends' / community perception of me changed.				X	X	X		
Other systems were affected by substance use.		X	X	X	X	X		
My own mindset aids my recovery.	X					X		
A family member supported me to come to COSUP.			X	X	X			
My family members assisted in paying for methadone.			X	X	X			
I feel I owe something to my family.			X		X			
Family is my primary support system.	X		X	X	X			
I sold some personal belongings to buy drugs.		X	X	X	X			
I have a positive relationship with my family.			X	X	X			
My mother is my main support.			X		X			
I encourage others to come to COSUP.	X		X					
I am not close to my family.		X						X

The phase of reviewing initially identified themes was a significant process to understanding the data. It enabled me to see which themes were not common, and which ones were. It also assisted me to identify which themes could be "condensed" into a single theme across participants, while still having to maintain the essence of each participant's viewpoint. During this process, phase four and five were recursive and happening almost simultaneously at times. Phase five is "defining and naming themes" (Clarke & Braun, 2013). Although this phase was initiated during the "reviewing themes" phase, it continued and evolved once the themes were sorted according to whether or not they were common across participants' answers or not. Some of the less common themes among participants include the following, provided by three out of eight of the participants:

- "My behaviours caused damage to my family."
- "The drug was enticing because it would relieve stress."
- "I didn't feel like a "normal, happy" person when I was using substances."

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- "I changed while using substances."
- "I was not close to my family due to my drug use."
- "Family / friends' / community perception of me changed."

The last two themes on this list are significant, as there is acknowledgement of the fact that one's actions impact on one's surrounding systems. As mentioned above, this is particularly notable considering the importance of community within the context of informal settlements, as well as the cultural background of the participants. Community and the interdependence that comes with it are remarkable. One theme that was reflected on by numerous participants was the fact that members of the community saw them (the participants) in a different light from before. They developed a reputation for being a "tsotsi" (thief), and there was an awareness that people (family members or members of the community) were suspicious of them. They mentioned the fact that they had become self-conscious and realised that they were dirty because of the way in which people looked at them or commented on their appearance.

One participant explained that members of the community began reporting his behaviour to his mother and other family members. This affected his relationship with his mother. She became a lot more suspicious of him and expected him to explain where he was spending his time and who he was spending time with, despite being an adult. He described himself as being dirty during that time, saying that he would dig through dustbins to find items to recycle in order to get money to support his habit:

Participant one: "Hmm, you see and sometimes you take from the bin [is] here in the street and then sometimes someone is seeing you and is going to tell your mama because I tried to so that I was at the dumping site early in the day."

These participants described the transition from being a respectable member of the community to someone who was judged and seen in a different light. Their addiction to drugs, specifically nyaope, began as a way in which they hoped to relieve the stress caused by everyday stressors. Several participants explained that they started using nyaope as a way to relieve stress. Considering the living conditions, socio-economic status and level of education of the participants, it was expected that their reasons for using substances would be unique, but it was not expected that stress would be such a prominent factor contributing to their use of substances. Participants identified financial stress, lack of job

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stability and having to provide for their families as factors contributing toward their stress. These factors illustrate how the participants were enmeshed with their immediate systems. They were aware of the role that they played within their numerous systems as well as how these systems impacted on their lives. They understood that they had to work to provide for their families. This was a major reason why participants started using substances. Once they had started abusing nyaope or had become dependent on the substance (experiencing the prevalence of withdrawal if they did not ingest the substance), their stress changed to worrying about how they would obtain their next "fix". The stress of providing for family became redundant, as the new focus became their day-to-day priority. This shift in focus means that they began disregarding the responsibility that they had toward their families in their efforts to meet other basic needs. The stress of getting the next fix while using the substance was expressed by a total of five participants.

Participant four: "If you wake up, even when you sleep before you can eat or do whatever you must, eish, you do it [use nyaope] first."

Although the above themes were less commonly expressed, they still proved significant in creating an understanding of the participants' experiences. The process of data analysis continued by focusing on the more common themes. Themes were then narrowed down according to those most commonly expressed by the participants, a continuation of phase five of the TCA process; "defining and naming themes". It then became a case of identifying how many participants had expressed themes in similar ways to one another and identifying the relevance of these themes to the study aims and objectives. The table below shows the common themes identified. These will be discussed further in terms of the aim of the research.

Themes	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**Comments**
I didn't feel like a "normal, happy" person when I was using substances.	X		X			X			X	4 of 8
I had to hustle to support my habit.					X	X			X	4 of 8

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I stole from my family.			X	X			X		X	4 of 8
The decision to stop was because I had a difficult relationship with my family.		X	X			X			X	4 of 8
Church / spirituality / prayer assist in recovery.		X	X		X				X	4 of 8
Family is my primary support system.	X		X	X	X					4 of 8
I sold some personal belongings to buy drugs.		X	X	X	X					4 of 8
When I was using drugs, I was stressed because I focused on getting my next fix.	X			X	X	X			X	5 of 8
Regret using substances	X	X	X		X		X			5 of 8
I no longer liked my lifestyle, I wanted to stop.	X	X	X			X			X	5 of 8
Methadone aids recovery.	X	X	X			X	X			5 of 8
Family is a supportive system.	X		X	X	X	X				5 of 8
Other systems were affected by substance use.		X	X	X	X	X				5 of 8
Now that I am attempting to recover, I am closer to my family.	X		X	X		X	X		X	6 of 8
I frequently felt ill, due to withdrawal symptoms.	X	X	X	X			X		X	6 of 8
I stole in order to support my habit.	X		X	X	X	X			X	6 of 8
My family was upset by my use because it did not align with our family values.	X	X	X	X	X	X			X	7 of 8
My family encouraged me to stop	X		X	X	X	X	X		X	7 of 8

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using substances.										
It is important that I get a job.	X	X	X	X	X	X	X		X	8 of 8

The following themes answered the research question directly: “What is the substance abuser’s experience of the role of family support in the recovery of a person who is addicted to psychoactive substances?”

- “Family is my primary support system.”
- “Family is a supportive system.”
- “Now that I am attempting to recover, I am closer to my family.”
- “My family was upset by my use of substances because it did not align with our family values.”
- “My family encouraged me to stop using substances.”
- “A family member supported me to come to COSUP.” (Friends also came up here)
- “My family members assisted in paying for methadone.”

The final phase of TCA according to Braun and Clarke is “writing up” (Clarke & Braun, 2013). Writing up provides the researcher the opportunity to provide insight into the significance of the study in relation to the research questions and, on a larger scale, in relation to existing literature. The remainder of this chapter as well as Chapter 6 are evidence of the final phase of TCA as applicable to the current study.

The above themes were identified across several participants’ responses. Participants identified family as playing an important role in their day-to-day lives. As mentioned by Stern (2015), most substance dependent individuals experience distance from family during their time of substance abuse. In her experience, this was not really by choice but as a result of the misguided actions and priorities of an addict (Stern, 2015). Most participants indicated that, while they were using nyaope and / or other substances, they had had a difficult relationship with members of their family and even some friends or community acquaintances. This is an obvious shift from their focus on supporting family financially as a theme identified above. Although this was evident, several participants explained that they had a generally positive view or experience of family as a notable system in their day-to-day living.

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Participant six: “Someone that cares, Ma’am. That’s family for me. Someone who takes responsibility, someone who will do something to help you, someone who sacrifice somewhere, somehow for him or her to help you...yes.”

Participant three: “I rely on my mother too much.... Because she is the one that…my mother, she believes me.”

This also clearly provides insight into the first primary objective of this study: “To establish how the participants define family”. Participants defined family as someone who is there for you and specifically mentioned immediate family members and partners. Although this perception and experience changed as they became addicted to nyaope, the process appeared to have gone full circle in the experience of the participants.

The experience of judgement from society and acquaintances is a common occurrence for individuals who battle addiction. Botticelli (2016) elaborates:

> So, you know, this is the stigma that people with substance use disorders face every single day, and you know, I have to tell you it’s still why I’m more comfortable coming out as a gay man than I am as a person with a history of addiction. (05:51)

When discussing the fact that they had been abusing substances, there was an acknowledgement by participants of the fact that their behaviour (using substances) did not align with the family values that had been instilled in them. The act of using substances was itself a betrayal of ingrained value systems, but behaviours such as stealing to support substance use and dependence contributed further to a feeling of being alienated from family, and what family meant to the participants. This was identified as a direct result of the use of substances; it was not normal behaviour for the participants and definitely affected their relationships with various family members. This also indicates the judgement that participants felt when they noticed a shift in the way community members viewed them.

Participant four: “Eish, because I was, I was making their hearts feel angry because when I was not at home they were not free because they know I am smoking and maybe I can steal from someone in the street, you know what I mean? Or maybe beat me or maybe kill me or even the police can arrest me.”

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Although participants expressed the view that their relationships with their families had been a lot more difficult while they were using substances, they generally agreed that family members had been there to encourage them to stop the use of substances. At times, this encouragement ended in arguments because the addicts did not agree with what was said. Participants described some family members as being angry and distrustful, blaming the friends that they were spending time with. Despite the frustration and anger there had also been members of the family who discussed with them the benefits and importance of abstaining from substance use. From the participants' answers this appeared to reflect their interactions with family members before substance use became a point of contention in the family. Participants explained that when they decided to start making use of the services of COSUP, a family member had gone with them and in these cases, paid the money required for them to obtain the medical checks and methadone which aids in the relief of withdrawal symptoms (MMT). By contrast, another participant said that his family was not aware that he was going to COSUP, but he knew that his ongoing use would have an impact on his ability to provide for his family, and he did not want this to affect his son. When asked if participants felt supported by their families, the responses were varied. Various responses included the feeling among some participants that the difficult relationship had improved once they had started trying to stop substance use; that they felt closer to their families now; and that, although their relationships with certain family members were strained, their families were willing to pay for the medication and take them to COSUP. In general, it seems that, although the family relationships had been quite strained during the time of substance use, the process of recovery was more in line with family values and therefore was supported by numerous family members. As a result, most participants felt that they had the support of their family and now felt closer to them during the process of recovery.

Interviewer: "OK, alright, so do you think that your family played a role in you getting better, and in your efforts to stop using drugs?"

Participant four: "Yes."

Interviewer: "How did they play a role?"

Participant four: "Uh, by almost encouraging me to stop using drugs and stop leaving."

Participant nine: "So up until last year...I told myself...I no longer...I don't have parents. It's only my brother and my granny I still have. So, let me quit the drug and try to change."

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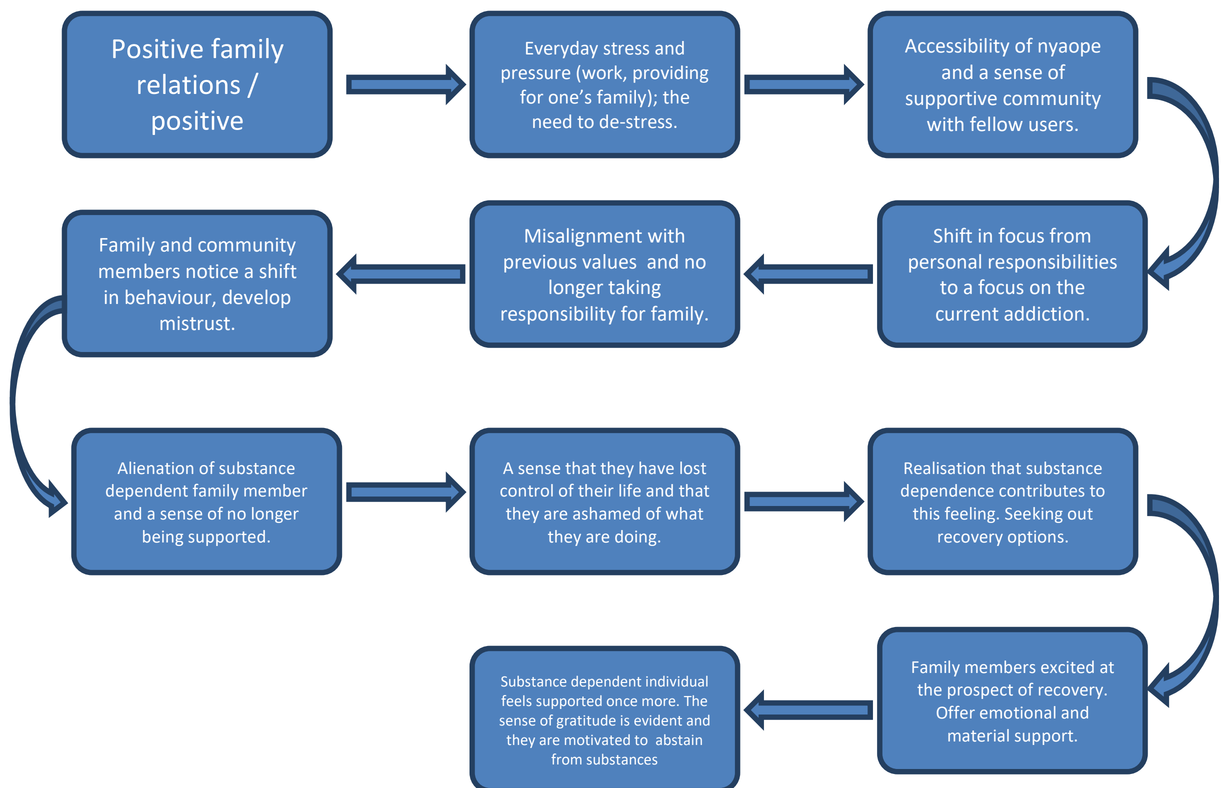
Participant six: "I got the support from now, when I started...maybe...leaving these drugs and everything. And then you saw...she saw my commitment and that's where things started to become OK. That's where I found her full support."

These quotations are important in addressing the research objective, "To determine how they perceive family support in their ongoing recovery process". Although the process was by no means "smooth sailing", participants ultimately felt supported, despite the rocky times and feeling of alienation at times.



There is a sincere sense of gratitude that, although their actions had a negative impact on their families, family members still provided support (financial and emotional) once the users expressed an interest in recovery, but not necessarily while they were still using. This gratitude led several participants to express the desire to do something to thank these family members.

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Participant six: "She...she...she helped me a lot, Ma'am. Going up and down for the transport for the CVs for me. She did help me a lot. Ja. So, I'd like to thank her. She wants a DSTV, so I am going to buy her a DSTV."

Although the acknowledgement of family support at the point of entering a recovery programme was prevalent, when participants were asked what they believed was enabling them to overcome addiction, specifically addiction to nyaope, the answer was, without hesitation: "methadone". Each participant explained that the withdrawal symptoms were painful and all-consuming and that, without methadone, they did not believe they would be able to overcome the addiction to this NPS. All participants felt strongly that methadone was the ultimate assistive factor in their ongoing recovery.

Participant three: "First it is this methadone and after it is God the way I see it."

Participant seven: "I think when I get a methadone I will stop."

Participant one: "The first time when I start to use this methadone um it was hard for maybe [for] 2 days but after 2 days it was fine, I was sleeping nice and eating (inaudible)."

Another primary objective of this study was "To establish what the factors are that help them to express an interest in recovery, according to their experience". It is clear that methadone was the strong assistive factor in the experience of the participants. However, it is noteworthy that participants also mentioned the fact that their actions and lifestyle choices did not align with family values, and that the scrutiny and judgement of community members had made them uneasy. I deduce that these factors prompted the interest in recovery but also that the participants experienced methadone as the true assistive element to recovery.

Some unanticipated themes surfaced during the interviews. It was interesting to hear from participants what their values are and what headed their list of priorities as recovering addicts. The following themes were notable from the interviews during data analysis:

"Church / spirituality / prayer assist in recovery."

Half of the participants indicated that they were engaging in church activities and prayer, and that they were overcoming their addiction by their God's grace. The focus was on service toward the church and engagement with the church community.

"It is important that I get a job."

This theme was common to all participants. They all indicated how important it was for them to find work. They did not specifically mention that this would play a role in their

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recovery, but they felt it was important in order to be able to provide for their families. This is congruent with what their priorities had been before starting to use substances. What is of concern is the fact that work pressures were identified as one of their major stress points and reasons for using substances initially. With MMT as a part of their recovery process, one hopes that they will be able to manage the stressors associated with working in a more adaptive way on their road to recovery. Furthermore, one may deduce that this is an important factor to them in creating a meaningful existence beyond their addiction to psychoactive substances.

"Eating well is a new priority."

Although only three participants mentioned it, it was striking that nutrition came up as a new priority. They acknowledged that eating had not been a prominent part of their routine when using substances. Participants also indicated that, if they did eat while using the substance, the food choice was generally unhealthy or not particularly nutritious.

"I no longer liked my lifestyle, I wanted to stop."

This theme seems to relate closely to the theme of participants' behaviour not aligning with general family values or expectations. Participants became aware of the fact that they were not living a healthy lifestyle. A general lack of personal hygiene was mentioned frequently. Participants explained that they did not practise high standards of personal hygiene while using substances and that this had been a notable change from their usual routine (when they had not been using psychoactive substances). The above three themes relate strongly to the fact that a general change to a more adaptive lifestyle is desired. The participants wanted to get back to employment, eat more healthily and lead a lifestyle generally more compatible with their values.

"I had to hustle to support my habit."

Numerous participants indicated that they had needed to hustle in order to get their next fix, acknowledging that this did not align with their usual behaviour. From the participants' responses, it is evident that hustling includes any behaviour that helped them to make money quickly, to be able to buy more drugs. This included selling expensive household items at very low prices as a quick solution to funding their next fix. They also indicated that stealing had become increasingly a part of their lifestyle. Stealing from family members appeared to be a common occurrence. These unanticipated themes do not

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directly address the research question or the aims of the study; however, they are relevant to the context of the study as well as to the overall conclusions, discussed in depth in Chapter 6.

The above themes, both anticipated and not anticipated, all provide context to the evolving interactions that participants had with their immediate system, family. Cumulatively, these themes speak to the aims and objectives of the study. Chapter 6 expands on these themes as they relate to the study and provides recommendations for possible further research.

5.3 Conclusion

Chapter 5 addressed the themes that were identified through TCA. Some valuable although unanticipated themes provided more context and substance to the experiences of the sample group, many of which are reflected in the literature explored in Chapters 2 and 3. From these themes, it is evident that family played an important role in the decisions of the participants; however, other factors also contributed to the participants' decision to take part in the recovery programme. The themes exemplify the fact that research of this nature truly is multi-faceted. Further discussion and interpretation of the findings is presented in the final chapter.

As Hari (2015) points out:

> And I think the core of that message – you're not alone, we love you – has to be at every level of how we respond to addicts, socially, politically and individually. For 100 years now, we've been singing war songs about addicts. I think all along we should have been singing love songs to them, because the opposite of addiction is not sobriety. The opposite of addiction is connection. (13:49).

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Chapter 6: **Discussion, Recommendations and Conclusion**

6.1 Introduction

The study aimed to find out what the experience of family support is during recovery from substance dependence, from the perspective of the addict. Furthermore, the primary objectives were: to establish how participants define family; to understand their perceptions of family, support, recovery and addiction; to determine their perception of family support in the ongoing recovery process; and to establish the factors that helped them to express an interest in recovery. This was in response to the research question: "What is the substance abuser's experience of the role of family support in the recovery of a person who is addicted to psychoactive substances?" Now that common themes have been identified, outliers acknowledged, and unanticipated themes recognised, a complete discussion of results can take place.

This chapter provides the interpretation of the identified themes. The results are related to the problem statement and primary objectives of the study, and any gaps still left by the research are identified. This provides insight into the importance of the current study. Recommendations for further research are then made.

6.2 Discussion and Interpretation of Results

In Chapter 5, it was identified that participants had difficult experiences during their time of substance use and dependence. Many of them expressed the feeling that they are still busy "finding their feet" in terms of repairing damage caused by their behaviours and habits. The transcriptions indicate that all but one of the participants had a generally positive view of what a family is. Those participants explained that they saw family as a supportive structure. It became clear during the interviews that participants had decided to stop their substance use because they had come to see how destructive their behaviour was, and they had realised that this behaviour was not aligned with their personal value systems.

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During the fifth phase of TCA; "defining and naming themes", elaborated on in the previous chapter, themes were condensed into the following four themes which provide insight into the main objectives of the study:

- Theme 1: Family is defined as immediate relatives and partners and is seen as a supportive structure.
- Theme 2: The lifestyle that participants were leading when using substances was not aligned with their own and their familial value systems. This realisation motivated their interest in recovery.
- Theme 3: Once participants had expressed an interest in recovery, they once again felt the support of their families.
- Theme 4: Methadone Maintenance Therapy (MMT) was ultimately, in the experience of the participants, the most prominent assistive factor in recovery.

Theme 1: Family is defined as immediate relatives and partners and is seen as a supportive structure. This theme emerged when participants were asked how they would describe the concept "family". The intention was to find out whether family was viewed positively and exactly *who* family was to the participants. Although participants mentioned a range of family members, from grandparents, siblings, children and parents to girlfriends, the most notable family member mentioned was their mothers. It can be denoted that the participants view family as traditional, consanguineous relations as described by Durkheim in Meyer et. al (2008). These are direct family ties and it is clear that the family members identified are direct siblings, parents whom the participants identified, independently. Most of the participants mentioned that their mother played an important role in their lives, to varying degrees. One participant claimed to be alone and not to have a family; another explained that a family is a support system. Participants stated explicitly that they had a positive view of families, while two participants expressed the directly opposing view. Family was generally described as participants' primary support system. This seemed contradictory, considering some of the difficult experiences that they described while they were using substances; however, these participants seemed to acknowledge that these difficulties had been the result of their own behaviour during the time of substance use. Hari (2015) supports the notion that those addicted to substances do make questionable choices, however points to the facts that treatment is archaic and accessibility to treatment programmes remains out of reach for many.

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He argues that their behaviours are therefore as a result of untreated and misunderstood disease and that once society at large reaches out to addicts, we may see a very different picture. In the present study, it is therefore evident that, before the participants' addiction, they had had a positive experience of family and family support. This appears to have shaped their perception that family is a positive and supportive structure. It is, however, clear that participants had experienced this on a sliding scale. They had experienced positive family interactions and a supportive family, but they had also experienced the opposite, in the form of the judgements of and estrangement from family members during the time that they were addicted to substances.

As explained in Chapter 3, different families have different dynamics and compositions; however, from the responses of the participants it may be deduced that the participants view family in the way described by Durkheim. Consanguineous and conjugal relationships were mentioned when they were asked to explain what a family is to them. Although I was prepared for the fact that some individuals might view friendship as a closer and possibly more supportive system than family, this was not evident in the participants' answers. Furthermore, should the study have been inclusive of all family types, this theme, may have been somewhat more extensive in order to have included different relations and, possibly, different perceptions.

Theme 2: The lifestyle that participants were leading when using substances was poorly aligned with their own and their familial value systems. This realisation motivated their interest in recovery. Participants realised that their lifestyle was misaligned with their values and hence changed their priorities during the process of recovery. Most of them said that they had realised that their behaviours at the time did not align with their family values. They realised that the theft, hustling and lack of hygiene did not reflect their upbringing and saw that this was contributing to their alienation from their immediate family system. Participants mentioned that they had had frequent fights with their family members and had lied to cover up certain behaviours, realising that this was because they were ashamed of what they were doing. Several of the participants explained that they had often been ill as a result of poor personal hygiene, not prioritising nutritious eating and frequent withdrawal episodes when they were unable to obtain nyaope.

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Chapter 5 mentions that participants had realised that many members of the community were judging them, and some mentioned that they had been ashamed of their behaviour, such as stealing, scratching through dump sites and dustbins, and generally what they were capable of. One participant reflected on the fact that members of the community would report to members of his family what he was doing and who he was seen with. Other participants mentioned that their lack of hygiene had become a source of embarrassment, as people would look at them strangely and they would feel uncomfortable when they were not under the influence of a psychoactive substance.

Although one participant said that he did not have family members who had been aware of his substance dependence, he mentioned his concern for his girlfriend and son. He said that he wanted to stop using substances because he knew that he was making bad decisions and was afraid that these would affect his son in future, as he had already lost his employment.

These are some of the many factors that appear to have contributed to the participants' realisation that they were no longer behaving in ways that aligned with their personal value systems. They were also able to see the correlation between these behaviours and the use and abuse of nyaope. What stands out here is how aware they were of community members' changing perceptions of them. They emphasised how important it was for them now to be clean and presentable. Participants also said that they had been eating more healthily since participating in the COSUP programme and receiving methadone. All the participants were unemployed at the time of the interview and said that it was because they had been unreliable while using substances. They all explained how important it was for them to get a job. This theme demonstrates the clear progression in the participants' priorities and values from the time they had been using substances to the time of the interview. Their interest in recovery was evidently prompted by the understanding that they were no longer leading a lifestyle that was congruent with their values and belief systems. This is an echo of Mokwena's research in 2017, in which it was found that nyaope users did not like who they had become. They felt inferior to those around them and wanted to find a way to overcome this feeling. The participants made clear reference to the fact that they were on a journey of self-improvement. They appeared to understand that this would be a difficult and ongoing process, but they clearly understood that there would be a better quality of life for themselves and those around them.

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Theme 3: Once participants had expressed an interest in recovery, they again felt the support of their families. Although the previous theme describes the disconnect and alienation felt by the substance dependent individuals who participated in this study, it also gives some insight into the reasons for their interest in recovery. Most of the participants explained that, during their substance use period, some members of their families had encouraged them to stop using substances. Six of the eight participants felt that their families supported their interest in recovery and said that they felt closer to them as a result and were experiencing family support once again. Participants had gone to COSUP as they had heard about the programme and that MMT was available. Their families had responded positively when they had been informed of their decision to seek help to recover from substance dependence. In most cases, families provided financial and emotional support, as well as encouragement, to participants who expressed an interest in abstinence.

The participants expressed the theme discussed above as a progression from a life without addiction to a life of addiction and then recovery from addiction. They had positive relationships with family, which had been negatively impacted by their addiction, and only after they had expressed an interest in recovery did they once again feel the support of some of their family members. After much encouragement from their family members and the realisation that they wanted to change their lifestyles, they experienced more family closeness, even though it is something that they have to work on together with their family members. By no means do these individuals have perfect relationships with their family; however, they reported a notable improvement in their relationships with family members. Some participants expressed immense gratitude for the support received from their families, also acknowledging the destruction they had caused under the influence of drugs. They seemed to realise that not only would they as individuals take time to recover, but their family system would undergo a process of recovery, too.

This is congruent with literature explaining that family is a primary system and, almost inevitably, a primary support, particularly during times of turmoil or adaptation. Literature from the likes of Hari (2015), Henninger and Sung (2014) and Botticelli (2016) all point to the fact that the historical approach of alienation and criminalisation, have not been effective. These authors argue that acceptance, education and the reduction of harm would

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go a long way in achieving lower rates of substance use and dependence as addicts and users are able to see that they are accepted and loved, despite their disease. In the case of the present study, the road to acceptance and support came through the participants' expression of interest in wanting to join a programme that would help them. Coincidentally, the programme that they had access to and which they heard of from friends and acquaintances is one such harm reduction programme. Although the process involved a great deal of difficulty, it is evident that the participants required and appreciated the support received from family members once they took action toward the process of recovery.

Theme 4: Methadone Maintenance Therapy (MMT) was ultimately, in the experience of the participants, the most prominent assistive factor in recovery. Participants acknowledged that they received support to aid their recovery and were grateful for that, but when asked what they believed had helped them to stop using substances, the answer was resoundingly "methadone". As explained in Chapter 3, MMT significantly reduces the symptoms of withdrawal experienced by those who choose to abstain. The success of MMT is widely recorded and applauded as a treatment method that heeds positive results (Worl Health Organisation, 2009). Mattick et al. (20014) extensively echo this sentiment, as well as the sentiment of the participants. The participants said they believed the withdrawals would have been unbearable without methadone, and that they would not have been able to stop usage without it. This also reflects Hari's (2015) and Botticelli's (2017) thinking that one should view addiction as a disease. Methadone is clearly a medication that assists in making the process of recovery more bearable, if not easier, for those who are addicted.

6.3 Limitations of the Study and Recommendations for Further Research

Although this study identified significant themes experienced by substance users in Pretoria, there are certain limitations that need to be acknowledged. The study did not aim to establish generalisable principles; however, because of the limited sample size and specific demographic profile of the participants, the question remains whether or not substance users generally have similar perceptions of family support during the recovery process. The sample was largely male, and it is not possible to see whether there might have been gender differences during the interviews of this sample. The substance of choice for this sample was

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nyaope. This NPS is unique in various ways. Given the nature of the community and the very specific withdrawal symptoms associated with this drug, participants' answers may have been a reflection of the users of this drug only, rather than substance abusers' views in general. Someone addicted to a different substance may have a vastly different experience due to different side-effects, more or less expensive substances, and lighter withdrawal symptoms. Furthermore, the members of this sample were using methadone to regulate their withdrawal and to assist in the process of recovery. Addicts undergoing a different kind of recovery programme might have a different experience of what aids or motivates their recovery.

Having discussed the findings and acknowledged the limitations of this study, I now make recommendations for possible adaptations in order to get a clearer understanding of a substance dependent individual's perception of family support during recovery. Substance use is an ongoing phenomenon globally. Further study and more generalised methods could provide breakthroughs in terms of prevention and treatment.

Firstly, it would be beneficial to study a larger sample of varying demographics. This would enable researchers to see whether or not the findings of this study are specific to the population group, residing in Mamelodi or people of a specific socio-economic status. Further research may reach new conclusions about different geographical or cultural groups.

Expanding the study from investigating the experience of family support to that of, more generally, "social support" would also be a valuable contribution to this gap in literature. Considering the previous discussion of the fact that some familial relationships could in fact be exceptionally maladaptive, exploring the experience of social support could be enlightening. It is true that the present study saw many mentions of friendships and community members in addition to the experience of support from their family members.

Conducting a study on individuals who use different substances of choice would provide insight into whether or not people using specific substances have different experiences of familial support. Considering the community that nyaope users build around the use of this drug, it would be necessary to explore whether users of other substances or poly drug users have a similar experience to one another. The question to ask here is: "Is the experience of family support dependent on the substance of choice?"

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Thirdly, studying various methods of recovery might also provide very different insights into the substance dependent individual's experience of family support, for example, exploring whether those using a drug assisted recovery programme, such as MMT, have a unique experience during recovery. Science-based programmes or other psychological treatments might yield very different results and might affect the experience of the recovering addict.

In order to obtain more definitive research, a focus group might provide further insight into the experience of this specific sample as well as others. The value of the focus group approach could be enhanced if family members were included as another element of data collection. The current study simply gauged the experience of the substance user. Hearing the experiences of family members could provide insight into other forms of support that were not necessarily recognised or received well by the participants. Although family support was not seen to be a factor motivating participants to seek treatment, they were eager to involve family members once they decided that recovery was their next step. Insight into the changing family dynamic before and during addiction as well as in recovery from addiction could be meaningful in developing future intervention programmes for recovery and family therapy.

6.4 The Value of these Results

From the literature it is evident that there is a global shift in the approach to addiction and recovery. There are numerous sources advocating a more supportive stance toward addicts as well as a movement to eradicate judgement and stigma in order to aid the treatment of addiction as disease. The participants in this study clearly valued the support they received from their families when deciding to participate in a recovery programme. Implementing this supportive stance, however, would require mass information sharing and educational efforts in order to target civilians of all socio-economic statuses, cultures and languages.

The study provided insights into the experiences of a very specific sample, not only into how they experienced the process from addiction to recovery but also into the lives they had led as addicts. Understanding the accessibility of the substance and the community surrounding the use of this particular NPS could assist in targeted intervention methods.

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These participants showed great initiative once they were aware of MMT treatment in their immediate area. The study further supports the ongoing use and implementation of MMT, to which participants without a doubt attributed their abstinence from substances.

The study aimed to understand the experience of addicts and the extent to which the family dynamic changes during the process of addiction. It provides an opportunity to develop family therapy interventions in order to aid reduction of harm strategies, which are proving to be the focus of substance eradication efforts. Understanding the participants' experiences provides information on a public platform that could help families and friends support addicts in a way that is conducive to recovery, as well as encouraging recovery at an earlier point in the substance-related disorder. Family and other social support could drastically reduce the harmful outcomes of substance related behaviours if society could reach a greater understanding of the roles that can be played in encouraging individual recovery and prevention on a larger scale.

Research in this area remains important in order to discover more ways in which addicts may be supported so that they do not resort to self-harm or destructive behaviours. Although the study found that familial support was not a factor while participants were using substances, it is evident that the role of family support at the time a decision was made to start treatment was important to them. Moreover, family members provided support that would have been inaccessible to addicts otherwise: financial and emotional support and encouragement. The gratitude that participants expressed for the support that they received at this point is encouraging. It provides space for further research to find out whether or not the role of family should be encouraged more openly.

Hari (2015) expresses the following view on the subject:

> I wanted to know how to help the people I love. And when I came back from this long journey and I'd learned all this, I looked at the addicts in my life, and if you're really candid, it's hard loving an addict, and there's going to be lots of people who know in this room. You are angry a lot of the time, and I think one of the reasons why this debate is so charged is because it runs through the heart of each of us, right? Everyone has a bit of them that looks at an addict and thinks, I wish someone would just stop you. And the kind of scripts we're told for how to deal with the addicts in our lives is typified by, I think, the reality show

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> "Intervention," if you guys have ever seen it. I think everything in our lives is defined by reality TV, but that's another TED Talk. If you've ever seen the show "Intervention," it's a pretty simple premise. Get an addict, all the people in their life, gather them together, confront them with what they're doing, and they say, if you don't shape up, we're going to cut you off. So what they do is they take the connection to the addict, and they threaten it, they make it contingent on the addict behaving the way they want. (12:04).

6.5 Overall Conclusion

The study found that, although family support was not a contributor toward addicts initiating a recovery programme, they found family support in their ongoing recovery valuable. Not only were they grateful for the financial support, they also found consolation in the fact that they once again had familial relationships. Although there is room for further study, the current study found valuable information which could aid future initiatives and interventions in terms of harm reduction and treatment programmes.

The study and its findings fully echo the still unpopular belief that addiction is a disease and that there is a need to support those who struggle with substance dependence in their recovery from their illness. How different things could be if we spoke to addicts about their difficulties and provided them with options to help, as we would with someone who requires treatment for cancer, heart disease, chronic migraines or diabetes. Although the behaviours of an addict often do not align with our value systems, knowing that those behaviours are the result of disease and then treating the disease could make all the difference.

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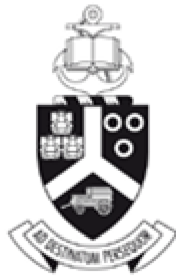
Appendix A: Interview Schedule



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Sub study of 83/2017 – Experience of family support in the recovery of individuals addicted to psychoactive substances

Biographical Information

Gender: ______ Age: ______
Race: ______ Socio-Economic Status: ________________________
Area of Residence: ____
Highest Educational Qualification: ____
How long have you abstained from ingestion of substances? _________________________
What substances were you using? ____
What was your substance of choice? ____

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Interview Questions

1. How would you describe the concept "family"?

   Probe: Find out whether family is viewed as blood relations only.

   Probe: Is family viewed positively?

2. What do you understand by the term "family support"?

   Probe: Considering your previous answer, what did you expect when (if) you needed personal support in your recovery?

   Probe: Is family viewed as a primary / reliable source of support?

3. Describe your experiences during the time that you were using substances.

   - Probe: Are there feelings of regret?
   - Probe: Were there feelings of being supported?

4. How do you believe your actions have affected your family?

   Probe: How are the participants' actions linked to my systems?

5. In what ways do you believe your behaviour affected other aspects of your day-to-day life?

   Probe: Is there acknowledgement of impairment of functioning within the societal system?

6. How have you achieved the process of recovery so far?

   Probe: What are considered helping factors?

   Probe: How has family played a part?

Interview no. _______

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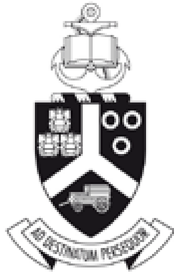
Appendix B: **Informed Consent Letter**



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Sub study of 83/2017 - Experience of family support in the recovery of individuals addicted to psychoactive substances

1. Purpose of the Study

The purpose of this study is to investigate how you experience family support playing a role in ongoing substance-dependence recovery.

2. Procedures

Individual interviews will take place between you and the researcher comprising a few questions which you can answer at your own pace. The interview will be approximately 20-30 minutes in duration. Your answers will be audio-recorded. The recordings will be used in order to determine whether the purpose of the study can be achieved. All results will be discussed in a dissertation, which will become the property of the University of Pretoria.

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3. **Benefits and Risks**

The results of this study could be quite beneficial to recovering substance users in future, as they may provide insight into the role that family support plays in the recovery of substance dependent individuals. There are no direct benefits to participants; however, your contribution may assist in initiating future research to promote the sustainable recovery of substance dependent individuals.

There are no direct risks to the participants of this study. The questions in the interview may, however, stir some negative emotions and sensitivity. The aim is not to make you feel uncomfortable or provoke negative emotions. Should you feel uncomfortable or uneasy, please contact one of the following institutions for free professional help:

- Itsoseng Clinic (Pretoria): (+27) 012 420 3111
- South African National Council on Alcoholism and Drug Dependence (SANCA) (Nationwide): 086 147 2662
-

4. **Participants' Rights**

Participation is voluntary, and you may withdraw from the study at any time without negative consequences. If you withdraw, any documents related to your participation will not be used in the findings of the study.

5. **Confidentiality**

All information that you will be providing will be treated as confidential. Data will be stored at the University of Pretoria in the Department of Psychology for a period of 15 years. As the researcher, I will have access to this information, and so will my supervisor, Dr Linda Eskell-Blokland. Your name will not be disclosed in the dissertation. Identifying information will be protected. However, biographical information that you provide will be noted in the discussion of the results of this study.

6. **Right of Access to the Researcher**

If you have any questions or concerns with regard to your participation, you are welcome to contact me from Monday to Friday between 09:00 and 16:00 on 083 409 4933 or at cb21730008@gmail.com.

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I, _________________________, fully understand the implications of my participation in this study. Furthermore, I am aware of my right to withdraw from participation in this study at any time during the interview, as well as of what the information that I provide will be used for and who will have access to it.

Signed on this day _________________________ at __________________________.

____

Participant

____

Researcher

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Appendix C: Declaration by Language Practitioner

I, **Glenda Holcroft, (ID 5103060026082)**, a professional language practitioner, declare that I conducted the language editing of this dissertation, "Sub Study Of 83/2017 – Experience of Family Support in the Recovery of Individuals Addicted to Psychoactive Substances", submitted by Candice Wepener.

Signature

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